A political-historical literature review of the statutory impact of the Traditional Health Practitioners Act (No 22, 2007) and the traditional health practitioner on the empowerment of the present and future South African healthcare establishment

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Thesis submitted for the degree Doctor of Philosophy in Governance and Political Transformation at the North-West University

Promoter: Prof A Duvenhage
Examination October 2017
Student number: 10056394
DEDICATION

I dedicate this study to the very few South Africans who have thus far dared to do research on and write about the Traditional Health Practitioners Act (22 of 2007) and the statutory recognition of the South African traditional health practitioners:

Each time a man stands up for an ideal,

or acts to improve the lot of others,

or strikes out against injustice,

he sends forth a tiny ripple of hope,

and crossing each other

from a million different centres of energy

and daring those ripples

build a current which can sweep down the mightiest

wall of oppression and resistance

(Robert Kennedy: in Price, 2014, p. 21)
DECLARATION BY STUDENT

I, Gabriel Petrus Louw, declare that the thesis: A political-historical literature review of the statutory impact of the Traditional Health Practitioners Act (22 of 2007) and the traditional health practitioner on the healthcare establishment of South Africa, is my own original work and design. All the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

This research is for the degree Philosophiae Doctor in Governance and Political Transformation, School of Government Studies, Faculty of Humanities, Potchefstroom Campus, North-West University and has not been previously submitted by me or anybody for a degree at another institution.

_________________________
GABRIEL PETRUS LOUW

_________________________
DATE SUBMITTED
DECLARATION BY PROMOTER

Hereby I, the co-author, Prof. A. Duvenhage, give permission that the five research- and descriptive-focused accredited articles and the 14 reference-focused accredited articles used in this thesis, may form part of the candidate’s PhD thesis. The contribution of the co-author was limited to professional advice and guidance as study leader towards the completion of the study.

________________________________________________________________________

PROF. A. DUVENHAGE/PROMOTER

________________________________________________________________________

DATE SUBMITTED
ACKNOWLEDGEMENTS

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Gabriel Louw

August 2017
ABSTRACT

The development of South African healthcare in the academic, research and practice fields is phenomenal. This development has always distinguished South African healthcare. At present, there are negative factors that may damage this development, growth and stability in healthcare. One of these factors – possibly the most important one – is the promulgation of the Traditional Health Practitioners Act (22 of 2007) (“the Act”), implemented in February 2013.

The Act (a) gives statutory recognition to traditional healers under the general name of traditional health practitioners, with registration of four categories of diviner, herbalist, traditional surgeon and traditional birth attendant, and (b) makes traditional healers full members of the South African health fraternity and sector.

The Act stirred up controversy with the first attempts to promulgate it in 2003, primarily because it is a first-world piece of legislation that is being applied to a third-world context of social and spiritual caregivers. In South Africa, this is a group without any conventional, recognized or certified training and education and they are now sanctioned by the South African educational authorities and the various regulated health councils. This move was driven by opportunistic activists, propagandists and politicians, regardless of the criticism against the legislation. It was promulgated without comprehensive research and in-depth consultation about the need for traditional health, the benefits it has for the country’s healthcare, the cost of implementing it, the negative effects that it may have on general healthcare and the regulated health professions, or an understanding of the training and skills levels of the present traditional healers. The short- and long-term consequences of the Act, as well as the role of the traditional health practitioners in the South African healthcare establishment, are clearly not well understood and have not been discussed by the public or the regulated health professions.

The Interim Traditional Health Council is now, in terms of its mandate described in the Act, busy with the registration of the first group of traditional health practitioners. The negative impact of the Act and of the statutory recognition of traditional healers on South African healthcare professionals can be devastating. There is an urgent need for an in-depth understanding of traditional healthcare and the act itself to offer guidelines for action to safeguard the country’s healthcare interests. There are five important matters to consider, namely the modern medical identity of the traditional healer in South Africa; the position that the Act takes compared to the Witchcraft Suppression Act (3 of 1957); the Act’s legal standing in the context of the resolutions of the Constitution of the Republic of South African, 1996; the possible impact of the Act as either
a godsend or curse on South African healthcare; and if traditional healers have any role to play as health practitioners in the healthcare sector. The research addressed these five matters.

**Keywords**: certified training, Interim Traditional Health Council, propagandists, regulated health professions, traditional healers and traditional health legislation.

**Note**: This text routinely makes use of masculine pronouns for ease of reading, and this in no way implies a sexist attitude.
LIST OF ABBREVIATIONS

ABET  Adult Basic Education and Training
AHPCSA  Allied Health Professions Council of South Africa
AIDS  Acquired Immunodeficiency Syndrome
AMA  American Medical Association
AMJ  Australasian Medical Journal
ANC  African National Congress
APA  American Psychological Association
ATPS  African Technology Policy Studies
AU  African Union
CAM  Complementary/Alternative Medicine
CTHP  Council for Traditional Health Practitioners
DFL  Doctors for Life
DOH  Department of Health
DUT  Durban University of Technology
FNHA  First Nations Health Authorities
HIV  Human Immunodeficiency Virus
HPA  Health Products Association
HPCSA  Health Professions Council of South Africa
ICD  International Statistical Classification of Diseases and Related Health Problems
ICMJE  International Committee of Medical Editors
ICTH  Interim Council of Traditional Healers
IFP  Inkatha Freedom Party
LHR  Lawyer Human Rights
MASA  Medical Association of South Africa
MCC  Medicines Control Council
MLA  Modern Language Association
MRC  Medical Research Council
NAMDA  National Alternative Medical and Dental Association
NAPPI  National Pharmaceutical Product Index
NCOP  National Council of Provinces
NDR  National Democratic Revolution
NEHAWU  National Education Health and Allied Workers Union
NHP  National Health Plan
NP  National Party
NPA  National Prosecution Authority
NPPHCN  National Progressive Primary Health Care Network
NQF  National Qualifications Framework
NSDA  Negotiated Service Delivery Agreement
NWU  North-West University
PCSA  Pagan Council of South Africa
RDP  Reconstruction and Development Programme
RSA  Republic of South Africa
SA  South Africa
SALRC  South African Law Reform Commission
SAMDC  South African Medical and Dental Council
SAMJ  South African Medical Journal
<table>
<thead>
<tr>
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<tr>
<td>SAPC</td>
<td>South African Pharmacy Council</td>
</tr>
<tr>
<td>SAPRA</td>
<td>South African Pagan Rights Alliance</td>
</tr>
<tr>
<td>SAPS</td>
<td>South Africa Police Services</td>
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<tr>
<td>SAQA</td>
<td>South African Qualification Authorities</td>
</tr>
<tr>
<td>SETA</td>
<td>Services, Education and Training Authority</td>
</tr>
<tr>
<td>SMASA</td>
<td>Self-Medication Manufacturers of South Africa</td>
</tr>
<tr>
<td>TAC</td>
<td>Treatment Action Campaign</td>
</tr>
<tr>
<td>TAM</td>
<td>Traditional African Medicine</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>THO</td>
<td>Traditional Healers Organization</td>
</tr>
<tr>
<td>THPC</td>
<td>Traditional Health Professions Council</td>
</tr>
<tr>
<td>THPCSA</td>
<td>Traditional Health Practitioners Council of South Africa</td>
</tr>
<tr>
<td>UDF</td>
<td>United Democratic Front</td>
</tr>
<tr>
<td>UJ</td>
<td>University of Johannesburg</td>
</tr>
<tr>
<td>URMSBJ</td>
<td>Uniform Requirements for Manuscripts to Biomedical Journals</td>
</tr>
<tr>
<td>USB</td>
<td>University of Stellenbosch Business School</td>
</tr>
<tr>
<td>UWC</td>
<td>University of Western Cape</td>
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<tr>
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CHAPTER 1

EXPERIMENTAL DESIGN AND RESEARCH DESCRIPTION

1.1 INTRODUCTION

There are few fields in healthcare that elicit such controversy as traditional healthcare. The various reactions - negative and positive - on the promulgation of the Traditional Health Practitioners Act (22 of 2007) (from here onwards “the Act”) and the statutory recognition of the traditional health practitioner as full partners of South Africa’s future healthcare establishment, are therefore not an unexpected surprise.

South African literature on traditional healthcare offers various opinions, views, postulations, generalizations and myths about the wholesomeness, excellent healing abilities, distinctiveness and indispensability of the traditional healer in the health system. Claims include statements such as that 80 per cent of all South Africans regularly consult traditional healers before consulting modern medicine; that there are 200 000 traditional healers in practice with a further 500 000 traditional healers working outside the formal biomedical system; that traditional healers are an important national health resource; that there is at present a dramatic evolution in traditional medicine and that the holistic treatment approach of the traditional healer is favoured above the Western healthcare approach. Literature alleges that the White governments of South Africa discriminated against indigenous healthcare and cultures and therefore limited their growth; that apartheid and its White supremacy led to the stunted development of traditional healing in South Africa. Other prominent postulations are that traditional healthcare is an essential and irreplaceable component of HIV/Aids (Human immunodeficiency virus/Acquired immune deficiency syndrome) care and physical and mental health, and that the traditional healer is therefore entitled to statutory recognition as an independent medical or health practitioner.\(^1\)\(^\text{17}\)

An in-depth review of governmental and popular literature on South African traditional healing shows a very one-sided, superficial and unscientific research approach and reporting. It reflects an approach that is most often based on citing old and not always trustworthy information. Explicit descriptions and analyses based on sound and in-depth research of historical events and facts, reliable and well-reported statistics and other supportive evidence to enlighten the role of the traditional healer, are absent from most literature.\(^1\)\(^\text{17}\)

Claims by South African traditional healers that they “act as a medium with the ancestral spirits,” that they are able to “interpret messages of ancestors,” that they “can bring luck, fidelity,
rainmaking," that, through their “sprinkling of muti around and about the kraal, they can ward of lightening” or "cause the witch discomfort in his bad endeavours," that they can “with muti destroys the powers in other people and can have people contract fatal diseases” and can "cast out the spell in cases of bewitching," are all accepted by the propagandists and many reporting researchers as true talents of the traditional healthcare practitioner, despite the fact that these claims are false and in conflict with modern healthcare and treatment, as well as contrary to the Witchcraft Suppression Act (3 of 1957), as amended by Acts 50 of 1970 and 33 of 1997.18-21

Mental impairment (especially the different kinds of schizophrenia and antisocial personality disorders), seem many times to be characteristic of traditional healers. This is accepted as normal and is defined as essential parts of the indigenous people’s culture. What is understood to be African culture is stretched to excuse abhorrent behaviour. Even the Act defines the term traditional philosophy as “uses of traditional medicines communicated from ancestors to descendants,” as a normal phenomenon that is accepted unquestioningly by all South Africans because it is a formal part of the Act.18-26

The introduction of the traditional healer as a recognized health practitioner to the general public of South Africa was thoroughly politically planned, especially since 1994. Political rhetoric about traditional healers and their “unique medicine” as victims of colonial powers, the apartheid regime and the Western/European health fraternity, became standard remarks in speeches, articles and other publications.8,9,27

Beyond the demand for the regulation of traditional healers and their recognition as health practitioners within the healthcare setup because they are said to be urgently needed, other unsubstantiated remarks are also plentiful. The Act is presented by the propagandists in favour of traditional healing as an absolutely necessary piece of legislation to stabilize traditional healing and to re-establish the traditional healer in the new South Africa.8,10

The impact of the Act and traditional health practitioners on South African healthcare workers has been completely ignored by the authorities, the healthcare establishment and the public. Urgent in-depth evaluation and discussion are pertinent to evaluate the possible outcomes of this legislation.

1.2 PROBLEM STATEMENT

It is impossible to review the Act and its various regulations, definitions and descriptions without paying attention to the political rhetoric surrounding it. The same is true for South African traditional healers and their traditional practices, which include traditional health products. The
emotional undertones of the current rhetoric affect reports on things like the number of traditional healers there are and the number of patients they see; their expertise; their schooling and professional training; their ethics; public needs and consultation uses; costs to healthcare, medical funds and schemes; ownership and delivery of traditional medicines; ratios between Western healers and traditional healers, etc.. An effort to put traditional healing in perspective requires an in-depth analysis of the Act and an interpretation of the Act as the starting point of research and discussion. Only after this can the assumptions, generalizations, deceptions and myths contained in the Act and the position, roles and impact of the South African traditional healer on South African healthcare be addressed.25

The post-1994 South African government, together with activists and propagandists in favour of South African traditional healing, want to ensure that a multifaceted, multicultural and multi-cosmological context for health and mental healthcare delivery comes to pass; one that includes traditional healers, no matter the costs, risks and uncertainty surrounding them. All legitimate objections against traditional healers and elevating the status of traditional healing to that of a South African official health service were ignored and trumped by a well-planned strategy, starting as early as 1969. The plan of the strategy is clear, namely to use the new democracy of South Africa as a vehicle to eradicate all remnants of the pre-1994 political, economical and social context, which includes the established Western healthcare sector and the regulated health professions.1-4,7,29-37

Literature clearly hints to the fact that the run-up to the promulgation of the Act was primarily driven and enforced by politics, coupled with the use of strong emotional overtures and supported by a misguided by a false and superficial idea of neo-African cultural distinctiveness. This emotional manipulation started nearly 40 years ago, and its proponents show a total inability to understand that the present advanced, modern healthcare of South Africa, which is crucial for South Africa’s future, is not necessarily inherently similar to a Western healthcare model that has political and anti-indigenous cultural inclinations for post-1994 politics.38

In post-1994 South Africa, there has been a crippling attack on establishments that are deemed Western, like healthcare. Activists claim that modern healthcare developed from colonial and apartheid influences and should therefore be shunned. Many people in public life, in healthcare, in academia and journalism have refrained from criticism or comment on developments related to health, religion, culture or indigenous matters, not only to be political correct, but also to stay out of conflict with or away from victimization by the present regime. The traditional healer as a new regulated health service partner is one of these topics. A curtain of “silence” has been drawn: the rights of the minority have been subjugated to those of the majority.29,39-42
It is therefore no surprise that the Act is a burning issue that attracts the attention of opportunistic, emotional and political agendas, false cultural distinctiveness, and pseudo-neo-African, but often outdated African intentions. The Act is projected as the saviour of the traditional healer and his indigenous culture, and the solver of the health problems of South Africa’s poor people. Its true impact on the South African healthcare section has thus far been ignored.25

Seeing that the Act has stretched over 12 years of formal parliamentarian plodding since 2005, but is still not fully operational in 2017, it is doubtful if the Act has a strong enough legal foundation to offer true statutory status for the South African traditional health practitioner. On the other hand it is also doubtful if South African traditional healers are equipped enough in terms of education, training and skills to become full members of the health sector to serve the public. The tardiness of the government with the abrogation of the Witchcraft Suppression Act (3 of 1957, as amended) despite strong opposition against it, seems to indicate that the government itself is still suspicious that traditional healers’ practices can get out of control without the act on witchcraft in place. The pertinent question is whether the traditional healer and the Act have a role to play in the modern South African healthcare establishment. Can traditional healers make a constructive contribution to the South African healthcare system by means of the Act?23,25

1.2.1 Guiding theoretical argument

The main aim of the Act is the professionalization of traditional healing in South Africa. The criteria of professionalization entail that the practitioners within the field should have an established stakeholder position in the country’s healthcare based on an established and tested training and healthcare model; acceptable professional ethics and patient relationships; professional relationships with the recognized healthcare practitioners within the healthcare sector; they should occupy a significant part of the country’s healthcare budget; and there should be a pronounced demand for that field among the broad population. This study argues that the above characteristics of a field ready for professionalization served as prominent arguments in favour of statutory recognition for traditional healers, even though these matters have never been tested. The most prominent of these claims is that they can make a positive and constructive contribution to the healthcare in South Africa. The Act’s chances of success and the possibility that giving traditional healers a share in the South African healthcare context can be positive, should be analysed, evaluated and reflected on by considering research and the practice.

The point of departure in proclaiming the Act and inviting traditional healers into the South African healthcare section has been that it is a positive development, until the contrary can be proven. This study therefore seeks to evaluate the Act and traditional healing as a field in an effort to
come to a conclusion about the preferable of these developments based on thorough research. This critical approach forms the basis of this thesis.

Each of the five articles included in this research examines one or more of the perspectives on the Act and South African traditional healers with the critical question of whether these developments are good in mind.

It is clear that no thorough study on this matter has been conducted. There is a dire need for an in-depth study on the Act and the role of traditional healers in the healthcare sector and given the healthcare needs of South Africans. The study embarks on a step-by-step analysis and interpretation of the Act’s various definitions, descriptions and clauses as reflected in its different sections, together with a consideration of historical and political facts, practices and traditions, and a look at training and a traditional healthcare culture in South Africa.

The research centres on one general research question that divides into five specific research questions to reflect on the truth of the claim that traditional healing can play a constructive role in the South African healthcare establishment. In an effort to answer the research questions, the study aims to reach one general objective and five specific objectives. The research is guided by one general hypothesis and five specific hypotheses, formulated in terms of the corresponding six research questions.

### 1.2.2 Research questions of the study

The following five research questions guided the research:

#### 1.2.2.1 Specific research questions

There are five specific research questions:

**RQ1:** Does the traditional healer have a modern medical identity in South Africa?

**RQ2:** Is the Traditional Health Practitioners Act (22 of 2007) in conflict with the Witchcraft Suppression Act (3 of 1957)?

**RQ3:** Is the Traditional Health Practitioners Act (22 of 2007) a mistake when considered against the Constitution of the Republic of South Africa, 1996?

**RQ4:** Is the Traditional Health Practitioners Act (22 of 2007) a godsend or a curse for South Africa's healthcare?
RQ5: Do the traditional healers have a role within the formal healthcare of South Africa as guided by the Traditional Health Practitioners Act (22 of 2007)?

1.2.2 General research question

There is one general research question:

GQ: Do the Traditional Health Practitioners Act (22 of 2007) and the role of South African traditional healers empower the South African healthcare system?

1.2.3 Objectives of the Study

The following five objectives guided the study:

1.2.3.1 Specific research objectives

There are five specific research objectives:

RO1: to determine if the traditional healer has a modern medical identity in South Africa;

RO2: to determine if the Traditional Health Practitioners Act (22 of 2007) is in conflict with the Witchcraft Suppression Act (3 of 1957);

RO3: to determine if the Traditional Health Practitioners Act (22 of 2007) is a mistake when considered against the Constitution of the Republic of South Africa, 1996;

RO4: to determine if the Traditional Health Practitioners Act (22 of 2007) is a godsend or a curse for South Africa’s healthcare; and

RO5: to determine if traditional healers have a role within the formal healthcare of South Africa as guided by the Traditional Health Practitioners Act (22 of 2007).

1.2.3.2 General research objective

There is one general research objective:

GO: to determine if the Traditional Health Practitioners Act (22 of 2007) and South African traditional healers empower the South African healthcare system.

1.2.4 Hypotheses

The following six hypotheses versus five alternative hypotheses are assumed:
1.2.4.1 Specific hypotheses

There are five specific hypotheses:

**H1:** The traditional healer does have a modern medical identity in South Africa.

**H2:** The Traditional Health Practitioners Act (22 of 2007) is not in conflict with the Witchcraft Suppression Act (3 of 1957).

**H3:** The Traditional Health Practitioners Act (22 of 2007) is not a mistake when considered against the Constitution of the Republic of South Africa, 1996.

**H4:** The Traditional Health Practitioners Act (22 of 2007) is a godsend for South African healthcare.

**H5:** The traditional healers do have a role within the formal healthcare of South Africa as guided by the Traditional Health Practitioners Act (22 of 2007).

1.2.4.2 General hypothesis

There is one general hypothesis:

**HG:** The Traditional Health Practitioners Act (22 of 2007) and South African traditional healers empower the South African healthcare system.

1.3 METHODS AND PROCEDURES

In light of a lack of sound research on South African traditional healers, traditional healing and the Act, this study did not start out with a single, defined viewpoint or hypothesis to test or to approve (see 1.2.4: Hypotheses). The researcher therefore sought to construct a viewpoint and to form a conclusion based on the evidence as the research develops. It is an interactive process of looping back and forth, developing ideas, testing it against new information, revising the ideas, building a basis, to be highlighted by new evidence and to rebuild it anew. This is a continuous cycle of research, repeated until everything forms a coherent whole that tells a logical story. A literature review was the most suitable method for this approach.

The research design is qualitative in nature in that a phenomenon from the “real world” is explored. The lack of information on South African traditional healers necessitates an exploratory and descriptive research approach by way of a literature review, with the simple aim of gaining insight into the situation, phenomenon and legal position of the traditional healers. Ultimately, the
thesis tells a story. The primary sources for this exploratory and descriptive research included contemporary journals and newspapers, government documents, archive collections, memoirs, collected papers and manuscript collections. Books and unpublished materials were viewed as secondary sources.43,44

The above exploratory research approach is in line with modern research in the field of history by means of investigating and reviewing research. It is underwritten by most North American and West-European universities where specific contemporary newspaper reports and articles are used as primary resources to reflect present-day life situations, thinking, opinions, trends and activities, but also to put the future in perspective.44 This approach was used for all five articles discussed in this study.

The databases used in this study were EBSCOHost, Sabinet online and various contemporary sources like newspapers, reports, articles, books and official documents. These sources reflect the opinions, viewpoints and thinking on the Act and on South African traditional healers. The findings are presented in narrative format.

The thesis includes five descriptive research articles, published by the author from August 2016 to March 2017 in accredited journals. Three of these articles were published in an international journal and two articles in a national journal. The five articles are presented from Chapter 4 to Chapter 8 and together they tell a story with a specific sequence. The original published articles are attached as Addendums A1 to A5. Three of these articles were published in the Australasian Medical Journal (AMJ) (http://amj.net.au) and another two in (http://ensovoort.com).46,47

The contents of a further 14 articles, also published nationally and internationally, were used to compile Chapters 2 and 3. These two chapters provide the historical-political and the legal background of the five—descriptive research articles. The original 14 articles are attached as Addendums B1 to B14, published between August 2016 and March 2017. Thirteen articles were published in the Australasian Medical Journal (AMJ) (http://amj.net.au), while one was published in the national journal Ensovoort (http://ensovoort.com).46,47

The research was based on two approaches:

- an analytical research approach, where a single article analyses and describes a specific focus (subject matter) related to the South African traditional health fraternity;
• a **general research approach** that includes the five articles as a whole to reflect, analyse and describe the full South African context related to traditional healing:
  
  o the legal contribution of the Traditional Health Practitioners Act (22 of 2007) and that of the South African traditional healing and the healthcare status, position, skills, and competence of South African traditional healers; and
  
  o the beliefs, opinions, and views of the established healthcare fraternity, researchers and the general public on the Traditional Health Practitioners Act (22 of 2007), South African traditional healing and the traditional healers themselves.

1.3.1  **Research approach**

1.3.1.1  **Analytical research approach**

The analytical approach of this research differentiates between five points of research. The five articles each address one of the five specific research questions (See 1.2.2.2). This is followed by five specific subscribed objectives (See 1.2.3.2) and five specific hypotheses (See 1.2.4.2), in answer to each of the research questions.

1.3.2  **Bibliographic- and reference – style**

The reference style for all five descriptive research articles (Chapters 4 to 8), the experimental design and research discussion (Chapter 1), the introduction (Chapters 2 and 3), and the conclusion (Chapter 9) follow the conventions prescribed in the *Uniform Requirements for Manuscripts Submitted to Biomedical Journals*, as prepared by the *International Committee of Medical Journal Editors (ICMJE)*. The *Index Medicus* was used for abbreviations of journal titles in the bibliography.

Neither the *Australian Medical Journal (AMJ)*, nor *Ensovoort* prescribes an explicit limit on the length of articles submitted, but they both encourage authors to be concise. For AMJ, the articles must be typed either in MS Word, Open Office or RTF format, using *Times New Roman* front size 10 and single spacing. AMJ also describes a specific design format for publication of its articles, using the ICMJE style of reference.

1.4  **THESIS STRUCTURE**

This thesis is presented in the article format as approved by the Senate of the North-West University (NWU). It is formally described in the General Academic Rules 2016 of the NWU.
The thesis divides into the following nine chapters:

**Chapter 1: Experimental design and research description**

This chapter consists of the introduction, problem statement, objectives, hypothesis, method and procedure, and the thesis structure.

**Chapter 2: Political-historical literature reviewing of the promulgation of the Traditional Health Practitioners Act (22 of 2007) and the statutory recognition of traditional health practitioners in South Africa**

This chapter reflects on the political-historical literature on South African traditional healing.

**Chapter 3: Resolutions, implementations and implications of the Traditional Health Practitioners Act (22 of 2007)**

This chapter describes the resolutions, implementations and implications of the Act.

**Chapter 4 (Article 1): Does the traditional healer have a modern medical identity in South Africa?**

The aim of this chapter is to evaluate the existence of a present medical identity of the traditional healer in South Africa.

**Chapter 5 (Article 2): Is the Traditional Health Practitioners Act (22 of 2007) in conflict with the Witchcraft Suppression Act (3 of 1957) in present-day South Africa?**

This chapter evaluates if the Witchcraft Suppression Act (3 of 1957) is discriminative against South African traditional healers or against the Traditional Health Practitioners Act (22 of 2007). It also evaluates possible infringement of the Witchcraft Suppression Act (3 of 1957) in the course of practice activities of traditional healers.

**Chapter 6 (Article 3): The Traditional Health Practitioners Act (22 of 2007): a mistake when viewed against the Constitution of the Republic of South Africa, 1996?**

This chapter reflects on the possible present as well as long-term legal implications of the Act for the established healthcare practitioners, the public and the Constitution.
Chapter 7 (Article 4): The Traditional Health Practitioners Act (22 of 2007): a godsend or a curse on South Africa’s healthcare?

This chapter evaluates the present and future impact of the Act on the South African healthcare context and on patient rights. The possible destructive effects are a focus point.

Chapter 8 (Article 5): The present and future roles of traditional healers within the formal healthcare of South Africa as guided by the Traditional Health Practitioners Act (22 of 2007).

The focus of this article is around the question whether the traditional healer can play any role in healthcare in modern South Africa. The focus is furthermore on alternative pathways for traditional healers outside the resolutions and implementations of the Act.

Chapter 9: Summary, conclusions and recommendations

This chapter consists of a summary of the study, hypotheses testing and confirmation, conclusions and recommendations.
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DESCRIPTION OF INFORMATION TRANSFERRED
FROM CHAPTER 1 TO CHAPTER 2

South African literature on traditional healthcare offers various opinions, views, postulations, generalizations and myths about the good nature, excellent healing abilities, uniqueness and indispensability of the traditional healer in the health system. Other prominent postulations are that traditional healthcare is an essential component of HIV/AIDS care and physical and mental health, and that the traditional healer is therefore entitled to statutory recognition as an independent medical or health practitioner.

An in-depth review of official and popular literature on South African traditional healing shows a very one-sided, superficial and unscientific research approach. It reflects an approach that is based most often on outdated and unscientific information. Most literature sources lack accurate descriptions and analyses based on sound research of historical events and facts, reliable and well-reported statistics and other supportive evidence to elucidate the role of the traditional healer.

The impact of the Act and the recognition of traditional health practitioners on South African healthcare have thus far been ignored by the authorities, the healthcare establishment and the public. Urgent in-depth evaluation and discussion of these factors are important in an effort to predict the possible outcomes.

It is impossible to review the Act and its various regulations, definitions and descriptions without paying attention to the political rhetoric surrounding it. The same is true for South African traditional healers and their traditional practices, which include traditional health products. The emotional undertones of the current rhetoric affect reports on things like the number of traditional healers there are and the number of patients they see; their expertise; their schooling and professional training; their ethics; public needs and consultation uses; costs to healthcare, medical funds and schemes; ownership and delivery of traditional medicines; ratios between Western healers and traditional healers, etc. An effort to put traditional healing in perspective requires an in-depth analysis of the Act and an interpretation of the Act as the starting point of research and discussion. Only after this can the assumptions, generalizations, deceptions and myths contained in the Act and the position, roles and impact of the South African traditional healer on South African healthcare be addressed.25

Seeing that the Act has stretched over 12 years of formal parliamentarian plodding since 2005, but is still not fully operational in 2017, it is doubtful if the Act has a strong enough legal foundation to offer true statutory status for the South African traditional health practitioner. On the other hand it is also doubtful if South African traditional healers are equipped enough in terms of education,
training and skills to become full members of the health sector to serve the public. The tardiness of the government with the abrogation of the Witchcraft Suppression Act (3 of 1957, as amended) despite strong opposition seems to indicate that the government itself is still suspicious that traditional healers’ practices can get out of control without the Act on witchcraft in place. The pertinent question is whether the traditional healer and the Act have a role to play in the modern South African healthcare establishment. Can traditional healers make a constructive contribution to the South African healthcare system by means of the Act?

The point of departure in proclaiming the Act and inviting traditional healers into the South African healthcare section has been that it is a positive development, until the contrary can be proven. This study therefore seeks to evaluate the Act and traditional healing as a field in an effort to come to a conclusion about the preferable of these developments based on thorough research. This critical approach forms the basis of this thesis.

In light of a lack of sound research South African traditional healers, traditional healing and the Act, this study did not start out with a single, defined viewpoint or hypothesis to test or to approve. The researcher therefore sought to construct a viewpoint and to form a conclusion based on the evidence as the research develops. It is an interactive process of looping back and forth, developing ideas, testing it against new information, revising the ideas, building a basis, to be broken by new evidence and to rebuild it anew.

The research design is qualitative in nature in that a phenomenon from the “real world” is explored. The lack of information on South African traditional healers necessitates an exploratory and descriptive research approach by way of a literature review, with the simple aim of gaining insight into the situation, phenomenon and legal position of the traditional healers. Ultimately, the thesis tells a story. The primary sources for this exploratory and descriptive research included contemporary journals and newspapers, government documents, archive collections, memoirs, collected papers and manuscript collections. Books and unpublished materials were viewed as secondary sources.

The databases used in this study were EBSCOHost, Sabinet online and various contemporary sources like newspapers, reports, articles, books and official documents. These sources reflect the opinions, viewpoints and thinking on the Act and on South African traditional healers. The findings are presented in narrative format.

The thesis includes five descriptive research articles, published by the author from August 2016 to March 2017 in accredited journals. Three of these articles were published in an international
journal and two articles a national journal. The five articles are presented from Chapter 4 to Chapter 8 and together they tell a story with a specific sequence.

The contents of a further 14 articles, also published nationally and internationally between August 2016 and March 2017, were used to compile Chapters 2 and 3. These two chapters provide the historical-political and the legal background of the five–descriptive research articles.

The analytical approach of this research differentiates between five points of research. The five articles each address one of the five specific research-questions. This is followed by five specific subscribed objectives and five specific hypotheses, in answer to each of the research questions.

The general research approach reflects the general research -question with its own, single subscribed objective and hypothesis.

The reference style used for all five descriptive research articles (Chapters 4 to 8) as well as for the Experimental design and research description (Chapter 1), the Introduction (Chapters 2 and 3) and the Conclusion (Chapter 9) offered in this thesis adheres to the Uniform Requirements for Manuscripts Submitted to Biomedical Journals (URMSBJ), as prepared by the International Committee of Medical Journal Editors (ICMJE).

Doing original research on South African traditional healing as a statutory profession and compiling a conclusion in answer to the questions listed in Chapter 1 necessitates a look at the political history that influenced the recognition of traditional healthcare as a healthcare profession in the country’s healthcare sector. This endeavour follows in Chapter 2. Chapter 2’s findings on the political-historical background of South African traditional healing come into play in Chapter 3, which researches the legal standing of traditional healing in terms of the Act. Both Chapters 2 and 3 serve as informative and supportive chapters to Chapter 1 (experimental design and description) and Chapters 4 to 8, which evaluate the statutory impact of the Act and the traditional health practitioner on the South African healthcare sector.
CHAPTER 2

A POLITICAL-HISTORICAL LITERATURE REVIEW OF THE PROMULGATION OF THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) AND THE STATUTORY RECOGNITION OF TRADITIONAL HEALTH PRACTITIONERS IN SOUTH AFRICA

2.1 INTRODUCTION

The statutory recognition of South African traditional health practitioners in terms of the Act seems to be politically motivated. Political leaders and opportunistic politicians with masked agendas abuse traditional healers as a Black cultural heritage that must be conserved at all costs. This unhealthy political climate was also very well utilized by the traditional healers themselves to advance their own interests, like the promulgation of the Act and their professional status as traditional health practitioners within the South African healthcare sector.

The South African state (post-1994) and the African National Congress (ANC) regime did not stay neutral with the promulgation of the Act. For opportunistic reasons, they favoured the recognition of traditional healers, in essence pre-modern cultural, religious and medical practitioners, as official statutorily regulated healthcare practitioners and professionals. They failed to adhere to the Constitution and they put indigenous South Africans in a situation of a new apartheid (although now a cultural, medical and religious one) and regressed to the Middle Ages by disregarding citizens’ healthcare needs and safety with the Act. At the same time, certain groups of Black people are belittled and degraded by certain Black leaders under the cloak of a false neo-Africanism, all the while claiming their right to think and to live freely in a democratic society, especially on healthcare.

The political influence of the ANC in the promulgation of the Act and the statutory recognition of the traditional healer as a healthcare practitioner has thus far been ignored by the general public, established healthcare professions and formally established healthcare sector of South Africa. This matter should be addressed urgently for us to understand the position of the Act in healthcare and to obtain insight into the possible positive or negative impact on future healthcare.

This chapter offers a political-historical background of traditional healing to highlight the development and the promulgation of the Act. This chapter supports Chapters 4 to 8, which evaluate the statutory impact of the Act and the traditional health practitioner on the South African healthcare sector.
2.2 THE ANC’S CHANGEOVER FROM A LIBERATION MOVEMENT TO A POLITICAL PARTY

“African parties are essentially products of a ‘colonial situation’ – in the sense of a situation in which an indigenous society is politically, economically, and culturally subordinate to a dominant European group,” writes Hodgkin. The birth of the ANC on the 8th of January 1912 in Bloemfontein was no exception. In the case of the ANC, domination came from another indigenous group in South Africa, although initially from mainly European decent, namely the Afrikaners. The subordinates were predominantly the Blacks, made up of four broad Black ethnic groups: the Nguni (Zulu, Xhosa and Pedi), the Sotho (Tswana and Sotho), Venda and Tsonga. The Coloureds and Indians also formed part of these subordinate groups. This dominance was built around racial discrimination in its extreme form during apartheid. It had its roots in 1671 at the Cape of Good Hope. The more extreme manifestation of this racial discrimination started in 1948 with the election of the National Party as government and the resulting policies that formed grand apartheid. It officially continued up to 1994 with the new political dispensation.

It became clear for Blacks since 1910 that despite some adaptations to the discriminative political system and concessions by the White rulers over the years to “better” racial relations and Black lives, extreme White dominance and racial discrimination would be part of the South African political system for a long time. It was impossible in this context of suppression, subordination and dominances for Blacks to remain passive or to leave it unquestioning. There was no chance to change this state of affairs with non-violent action. In practice, Black people had two political choices since 1910: to act revolutionary or to conform. Initially, the status quo was followed by most Blacks and they accepted the oppression, but in light of the growing negative racial attitudes of the Afrikaners and the degrading of Black people’s humanity, Blacks began to organize themselves in political groupings, although not revolutionary or near-revolutionary in the beginning. The founding of the ANC in 1912 was basically to protect and promote Black interests all over South Africa. As early as 1917, Communists became active in South Africa and they infiltrated trade unions and in 1921 the first Communist Party was established on African soil in the Union of South Africa. Soon after they infiltrated the ANC and in 1936, JB Marks, a communist, became the ANC’s secretary general. After this, there was very little difference in the political ideologies regarding the fighting and overthrowing of the regime of the National Party between the two bodies. In 1959, Robert Sobukwe broke away from the ANC because of the communist domination and what he regarded as a too lenient approach to White dominance, and he formed the Pan Africanist Congress.
After this break-away, the ANC still remained the most dominant Black liberation grouping, starting to reflect revolutionary thinking and behaviour in their effort to oust the Afrikaners regime or to affect the Afrikaner regime’s total and immediate withdrawal from all positions of dominance in the military, economy, and political and administrative spheres of the country. This radical inclination, coupled with terroristic actions, led to the banning of the ANC in April 1960 and the imprisonment of many of its leaders.\textsuperscript{19,21,25}

Since the 1950s, even before its banning as a political organization, the ANC put various manifestos on the table, reflecting its wishes and views on how a future South Africa had to be ruled. The correction of human rights and equal service delivery were prominent. The 1955 Freedom Charter, the first of these ANC guidelines, reflects this well, and although not described in depth, made the above point of political attention that continues today.

The dissatisfaction of the ANC with the National Party’s discriminative healthcare policy for Blacks was more than justified. In 1994, with the new political dispensation, the responsibility of offering better healthcare to Blacks became that of the ANC, and the chaos of the existing healthcare system was dumped onto the ANC regime. The next subdivision offers an overview of the chaos within healthcare in general in 1994 when the ANC came to power. It also indicates the challenges that awaited the ANC in finding solutions quickly to rectify the National Party’s (NP) incompetent and racist healthcare policies and services. Many Blacks saw the traditional healers as saviours of the ineffective healthcare sector.

\section*{2.3 SOUTH AFRICA’S FORMAL HEALTHCARE SERVICES AND ESTABLISHMENTS IN 1994}

Healthcare during apartheid was characterized by inequality, and this spanned nearly a century. The system undoubtedly needed fundamental reconstruction to remedy this, including enormous financial input. In 1994, during the transfer of political power to the ANC, the country was trapped into developmental or financial stagnation, starting in 1990 with a South African economy showing zero or negative growth. It was not possible for the incoming ANC regime to provide in all the basic healthcare needs of the majority of its supporting voters immediately. These voters expected the ANC to offer them a better standard of living than the NP did. Indeed, besides the financial crisis in healthcare delivery, the existing healthcare services were so inefficient, inequitable and fragmented that they failed to meet the basic healthcare needs of the broad population, especially the Blacks, notwithstanding immediate corrections.\textsuperscript{27}

Savage and Shisana\textsuperscript{27, p. 97} identified six negative indicators in healthcare services in 1995:
• **Deep financial inequalities within services.** The per capita national expenditure on health services was for instance biased towards Whites with R597.00 per capita for the Whites against the R138.00 per capita for Blacks; there were marked inequities in the financing of different levels of healthcare services with primary healthcare services receiving only more or less 5 per cent of the national healthcare expenditure.

• **Existing healthcare services were deeply fragmented.** Up to 1995 14 separate ministries of healthcare were active in the South Africa, with a lack of coordination between them. Fragmentation in the organization of services with a weak referral chain between different levels of services led to inappropriate use of hospital services and healthcare personnel.

• **Organization of provision of curative medicine and capital-intensive technology were executed at the expense of preventive medicine and primary healthcare.** Only 5.4 per cent of the healthcare budget was devoted to the promotion of “good” health, while healthcare was disease- and hospital-centred.

• **Maldistribution of medical personnel.** Of the medical doctors registered in 1994, only 5.5 per cent were practicing in rural areas where more than 40 per cent of South Africans resided. In this scenario, 65 per cent medical doctors practiced in metropolitan areas, 11 per cent in cities, 12 per cent in towns and 6 per cent in small villages.

• **Marked and growing divide between public and private provision of healthcare services.** More or less 63 per cent of all doctors active in the country were working in the private sector, which only served 20 per cent of the population. This population group could afford medical aid or medical benefit schemes or could afford private healthcare from their own pocket. In practice, a private healthcare system had emerged that provided for the needs of 69 per cent of Whites against 5 per cent of the Blacks and 30 per cent of the Coloureds who were on medical aid schemes, while the public healthcare sector provided for the bulk of the South African population.

• **Weakly developed ancillary services.** In 1991, the number of registered nurses was 67 843, enrolled nurses 72 484, health inspectors 2 471, dentists 3 768, dental therapists 141, optometrists 1 168 and pharmacists 8 171.

The healthcare problems the ANC faced in 1994 were not open to easy solution and a new framework for the organization of healthcare to all South Africans was urgently required. The ANC, as the new regime, faced a basically impossible task to rectify the problems in a decade and to bring equal healthcare to all South Africans. On the other hand, the ANC had foreseen this chaos to a certain extent and they formulated theoretical plans with respect to what was wrong
with South African healthcare and what must be done in an effort to revamp it from 1955 onwards (for a detailed description see later subdivision 2.5).

2.4 OPTIONS FOR POST-1994 HEALTHCARE PROVISION IN THE NEW SOUTH AFRICA

In 1994 the ANC identified four options for the provision of healthcare with their role as a regime in mind. They also identified the role of the private sector, if any, in the funding and provision of healthcare.27

- **Nationalize the private sector.** This would bring all healthcare facilities and personnel under state control.

- **Keep the public and private sector healthcare provision separate.** This would allow private healthcare to continue for those who wanted and could afford it; while the process would be activated to build and reorganize public (state) healthcare services.

- **Centralize funding for both public and private providers.** The intention was to create a national healthcare insurance system that would be run on compulsory contributions from all the role-players involved in formal employment and that would provide a basic package of healthcare services for all citizens.

- **Business sector healthcare provision.** This would create a situation where the state would still be responsible for the healthcare services of the broad public, but the business sector would provide healthcare services to their employees and their dependents.

2.5 THE ANC’S VARIOUS HEALTHCARE POLICIES: 1955 – 2017

It was clear that the demands and challenges of the South African healthcare in 1994 were immense. It was clear that the incoming ANC regime would found it difficult to meet the expectations of the suppressed Blacks for better healthcare services or access to basic healthcare facilities.27 On the other hand the ANC had already started preparing for South Africa’s complexity of healthcare problems that would await them when they take office one day by 1955.

2.5.1 The Freedom Charter of 1955

One of the main tasks the leadership of the ANC took on themselves in promoting Black interests (and obtaining political support) was the adoption and publishing of *The Freedom Charter* on 26 June 1955 wherein the ideal political, social, citizen and economic rights of Blacks (as well as Whites) were described. It also served as an example and “guarantee” of how the ANC would address healthcare problems when they come to power. Although this five-page document is
today treated as an extraordinary document with respect to human rights and as a first guideline for Black rule, the contents are vague and insufficient in defining the rights and needs of Blacks at that time. Also, how the ANC intended to gain and maintain these rights and needs were insufficiently described. Healthcare, a cornerstone in the policy of discrimination by the NP regime, was also insufficiently described and not anchored in constructive remedies. The only references to healthcare in The Freedom Charter, under the subdivision: There Shall be Houses, Security and Comfort! is the following two sentences: A preventive health scheme shall be run by the state, and: Free medical care and hospitalization shall be provided for all, with special care for mothers and young children.21,28

It is clear that the ANC management lacked a thorough understanding and experience of a well-structured healthcare system in terms of service delivery and human resources when they came into power. Second, in their declaration on healthcare, they underwrote the established healthcare system and human resources that were active and practising in South Africa in 1955: a Western, modern and scientific model (and not an African model based on traditional healing or an African-orientated healthcare approach). Third, they clearly wanted to bring together two healthcare components: the established modern, Western healthcare system and modern, Western professional human resources in an effort to continue and to improve healthcare and to extend this to all Blacks on the same basis as it was offered to the privileged Whites at that time. There is no reference to a radical deviation from the modern, Western kind of healthcare model, system and profession as it existed in 1955. Any recognition and implementation of traditional healing or inclusion of traditional healers in the existing healthcare systems is absent from their plan. The lack of literature on traditional healing itself and as part of the ANC’s policies on future healthcare in South Africa before 1992, confirms this.21,28

It is important to take note of the wording of some statements contained in ANC policies, like “no government can justly claim authority unless it is based on the will of all the people;” “our people live in brotherhood, enjoying equal rights and opportunities;” “all people shall have equal right to use their own languages, and to develop their own folk culture and customs;” and “the government shall discover, develop and encourage national talent for the enhancement of our cultural life.” Activists use these clauses, seemingly supported by the guarantees of the individual’s civil rights as contained in the Constitution and the Bill of Rights, as “legal indicators” that traditional healing should receive statutory recognition. In reality these clauses were, as said, vague, lacking any description of traditional healers and clearly not applicable to the Constitution or the Bill of Rights.

The various declarations on the kind of healthcare that the ANC leadership wanted for the Blacks discussed below did not dramatically fill in the above vague descriptions on healthcare formulated
in 1955. There is no reference to any specific kind of future for traditional healers in any of the official guidelines and policies of the ANC up to 2012. Even informal recognition of traditional healers only gained momentum from 1990 onwards as a result of political influences and manipulation after the 1990 unbanning of the ANC, the new political openness of the NP to accommodate Black needs and preferences, and the NP’s slow disintegration as a political party.

2.5.2 The ANC’s “Ready to Govern” document of 1992

The ANC policy document of 1992, titled *Ready to Govern*, only states that the provision of equitable healthcare should be guided by the aspiration of the people as enshrined in the Freedom Charter and by principles that reflect the primary healthcare approach. It furthermore states that29, p. 25: “access to healthcare is a basic human right.” This is a clause that the ANC later wanted to be incorporated in the South African Constitution and the Bill of Rights. This reference was also contained in the Freedom Charter, which was indiscriminately used by activists and propagandists to support the arguments of traditional healers as appropriate healthcare practitioners in terms of Black cultural, customs and traditions.

2.5.3 The Reconstruction and Development Programme of 1994

In 1994 the *Reconstruction and Development Programme (RDP)* was published. One of the government’s primary aims with the programme was to develop a national health system, to offer affordable health care, to promote healthcare and the cure of illnesses in general, and specifically to offer primary health care. Its contents on healthcare specific read as follows30, p. 3-4:

“The national health system will...

- give free medical care to children under 6 years and to homeless children;
- improve maternity care for women;
- provide free services to disabled people, aged people and unemployed people within five years;
- organize programmes to prevent and treat major diseases like TB and AIDS;
- expand counselling services (for victims of rape, child abuse, and other kinds of violence);
- give women the right to choose whether to have an early termination of pregnancy;
- improve and expand mental health care;
- run special education programmes on health, aimed particularly at young people;
• improve occupational health in the workplace; and
• involve the fullest participation of the communities."

The ANC’s National Health Plan for South Africa (NHPSA) of 1994 also proposed the creation of a single comprehensive, equitable and integrated National Health System (NHS) that is founded on the principles of equity and the right to healthcare services and a primary approach to healthcare. The main aim was to improve access to healthcare services, to increase the comprehensiveness of good quality services to the entire population, to protect households from costly healthcare services and to eradicate communicable and non-communicable diseases in the community, as well as to promote healthy lifestyles and community participation in healthcare offerings.\textsuperscript{29} After 1994 the healthcare sector also introduced community service for certain categories of healthcare graduates to lessen the shortage for healthcare professionals, especially in rural areas, and to make quality healthcare cheaper and available to the poor. Once again, there was no reference whatsoever to traditional healers as primary healthcare practitioners within this setting.\textsuperscript{24,25,29,30}

2.5.4 The Roadmap for Reform of the Health System of 2007

The ANC’s 52\textsuperscript{nd} Conference held in 2007 again identified healthcare as an ANC priority. Shortcomings in the existing healthcare policies were identified and strategies were formulated. A basis was laid to better further healthcare delivery. This led to the development of the Roadmap for the Reform of the Health System. Traditional healing was absent again.\textsuperscript{29,31}

2.5.5 The Ten-point Plan for the Health Sector of 2008

A further outcome in the ANC planning on healthcare for all South Africans was the development of the Ten Point Plan for the Health Sector in 2008. The ten priorities of the plan are the following\textsuperscript{25-26,29}:

• Provision of strategic leadership and creation of a social compact for better health outcomes.
• Implementation of the National Health Insurance (NHI).
• Improving the quality of health services.
• Overhauling the health care system and improving its management.
• Improved human resources planning, development and management.
• Revitalization of infrastructure.
• Accelerated implementation of the HIV & Aids and Sexually Transmitted Infections National Strategic Plan 2007-11 and increased focus on TB and other communicable diseases.

• Mass mobilization for better health for the population.

• Review of drug policy.

• Strengthen research and development.

The Health Sector Ten-point Plan\textsuperscript{29, p.26} was set to be implemented through the Department of Health Programme of Action and the Negotiated Service Delivery Agreement (NSDA). The intention was to use the NSDA to strengthen the effectiveness of the established health system, to increase life expectancy, decrease maternal and child mortality, to combat HIV and Aids and to decrease TB. The focus was also on better access to healthcare services and eliminating the fragmentation of healthcare services.

2.5.6 The ANC Election Manifesto of 2009

The ANC Election Manifesto of 2009 states again that health is a key priority in planning for the ANC’s development policy for the period up to 2014. It specifically emphasizes the importance of health programmes, although there was again no deviation from the pre-1994 modern healthcare system. These outcomes were further analysed and supported by initiatives like the Henry J Kaiser Family Foundation’s An Overview of Health and Health Care in South Africa 1994–2010\textsuperscript{29,31,32}

2.5.7 “The ANC Policy Discussion Document: Education and Health” of 2012

The ANC Policy Discussion Document: Education and Health, dated March 2012 (18 years after the presentation of the 1994 Reconstruction and Development Programme, and 47 years after The Freedom Charter), on the one hand once again does not reflect any dramatic change in the mindsets of the ANC leaders on the established healthcare for South African people.\textsuperscript{29,30} On the other hand, it reflects the ANC regime’s commitment to maintaining modern healthcare standards for healthcare. Again there is no reference to traditional healing per se. This document states\textsuperscript{29, p. 3}:

The resolution of the 50th National Conference noted that since 1994 the point of gravity as regards to policy development appears to have shifted to government and away from ANC constitutional structures. It resolved to enhance the depth and extent of ANC capacity to sustain an ongoing cycle of policy development, implementation
and monitoring; and also adopted a diagrammatic aid to better an understanding of the ANC policy process.

These attempts of the ANC to better healthcare policies reflect their intention to do good to South Africans in general, as the following remark confirms\textsuperscript{28}, p. 3: "...assist the ANC to plan for the next five years of governance [2017]; help the movement to review existing documents on our vision of the ANC and South Africa in the next twenty years up to 2030; and get branches of the ANC to agree on our vision of the ANC and South Africa a hundred years from now, viz. The ANC and South Africa of 2112."


It is clear from the above that the ANC initially wanted to retain a modern and scientific healthcare system with professionals and scientific practices. The only change was that they wanted to better and further it after 1994. The 2012 ANC conference also made it clear that the established healthcare sector had to serve as a blueprint for future planning on the country’s healthcare. References to traditional healthcare or traditional health practitioners as future components of modern South African healthcare, or as official cultural role-players in the country’s healthcare sector, never appeared in any of the ANC documents from 1955. \textsuperscript{21,28}

The question in 2017 is how the traditional healers found formal inroads into the South African healthcare sector through the promulgation of the Act\textsuperscript{1} and how they obtained statutory recognition as healthcare professionals under the title of traditional health practitioner. Prominent in this context is how this outcome could be reached given their lack of professional training, healthcare history and standing among medical professionals in South Africa. The answer seems to lay in the traditional healers’ own various well-planned efforts to promote and position traditional healing, especially within post-1994 healthcare. Activists and propagandist aimed to convince politicians and the public of the importance of traditional healers in healthcare. This suited opportunistic politicians, who used this as part of their political manipulation on various terrains.\textsuperscript{11}

The PAC aptly formulates the new view on the future recognition, role and impact of a “Black culture” on healthcare since 1990. This shift was brought on by the initiatives of the NP, the post-1994 unwritten policy of political correctness and the unlimited rights of the individual as cemented in the Constitution and the Bill of Rights.\textsuperscript{11,31} Freeman\textsuperscript{31}, p. 69 writes: “It is their [PAC] view that African people have the right to express their value system unhindered, and as traditional healing
and African culture are inseparable, THs should be given the same status in society as healers from the modern health sector. The PAC believes that traditional healing could cure problems where the modern sector has failed. Payment for traditional healing would come from the same or similar source of payment for care in the modern healthcare sector." In the 1990s, the PAC had no doubt that as soon as a Black majority came to power, the legalizing of traditional healers would automatically follow. In 1994, the ANC came to power and in 2007 traditional healers were indeed legalized, although not immediately incorporated into the formal healthcare sector.\textsuperscript{11}

On the side of the ANC regime there was suddenly a strong justification for the statutory recognition of traditional healing and traditional healers as the healthcare professional called a traditional health practitioner within the official healthcare sector, despite its initial lack of a prominent view on traditional healing in its many formal healthcare declarations. The reason for this turn-around in the policy of the ANC, although initially pursued outside the formal structures, must be sought in the pressure from various kinds of supporters from all the classes and socio-economic levels of South Africa, especially the lower socio-economic levels where poverty, the belief in the supernatural and under-education are prominent. A resolution at the 1991 ANC conference gives an indication that the needs, requests, customs and traditions (like the statutory recognition of the traditional healer, although not formally expressed) of the masses who had supported and voted for the ANC would be respected in the future, even if this means ignoring any scientific evidence or warnings against it. The resolution reads\textsuperscript{25}, p. 36: “In formulating our policies for a democratic South Africa these should relate to mass struggles and provide opportunities for the masses to assert their just demands.” Also, the Constitution Section 27 serves as a strong argument for the activists and propagandists of traditional healing when it says that every South African “has the right to have access to health care services,” while the January 1994 National Health Plan for South Africa’s statement that “governmental health activities involve the fullest participation of the communities,” is generally interpreted as meaning that there is a transfer of decision-making of the entire healthcare delivery system and its institutions to the community. Some pro-traditional healing supporters and human rights activists who lack an understanding of the negative consequences of traditional healing, see the above statements as meaning that the individual has the right to any kind of healthcare that he prefers, making traditional healthcare justified\textsuperscript{23,29,32,33,34,35}

The prominent question is: are the views of the PAC and later the ANC lawmakers who contributed to the promulgation of the Act on the claimed benefits of traditional healers and their importance to South African healthcare based on true facts and sound arguments? Is the traditional healer truly a qualified healthcare practitioner, an important cultural figure and needed
in the Black population’s daily life? What impact does “political blindness and naivety” and emotional subjectivity have on the statutory recognition of traditional healers as health professionals from especially the lawmakers and politicians’ side? These questions should be answered before the contribution and impact of traditional healers on healthcare can be understood, evaluated and addressed. The various arguments offered in support of the promulgation of the Act are discussed in the next seven subdivisions (see subdivisions 2.6.1 to 2.6.7 of this Chapter for detailed description).

Over the years various unofficial arguments, statements and opinions have been offered on why traditional healing must be statutorily recognized and regulated. The motivations to the promulgation of the Act included the claim that there are 200 000 or more traditional healers practicing in South Africa; that the ratio of traditional healers versus medical doctors (and other healthcare professionals) is 7:1, confirming the high presence of traditional healers in healthcare; that the majority of South Africans, up to 80 per cent of the total population, regularly consult traditional healers; that their fees are lower than that of medical doctors; that the traditional healers are the sole owners of traditional medicines in the country and as such are legally entitled to practice traditional healing and medicine; that the income they generate from the sales of traditional medicines and products are enormous, confirming their established position as healers and the importance of their medicine in the country’s healthcare setup; and that they are still prominent religious leaders and spiritual healers in Black society. No facts were presented in these motivations before Parliament for the promulgation of the Act. As a result of their own political subjectivity and naivety, South African lawmakers in Parliament accepted these claims as true, despite abundant evidence to the contrary and legal objections against the lawmakers’ promulgation of the Act. In this political context of misinformation, emotionality and subjectivity, the Act was promulgated as a healthcare act that addresses the “African cultural needs and priorities.”

The various claims and motivations in support of the formal regulation of traditional healing are described in the following seven subdivisions.

2.6.1 Are there 200 000 or more traditional healers practicing in South Africa?

One of the motivators in the new South African political dispensation’s promulgation of the Act and the statutory recognition of traditional healers as traditional health practitioners in the South African health establishment, was the claim that at least 200 000 unregistered traditional healers (with some researchers putting the number as high as 400 000) are currently practising in South Africa (see Addendum B1). The claim continues to say that there is a great need for traditional
healers' skills, medicine and know-how among the public. These views on the traditional healers are still reflected in South African literature today.\textsuperscript{3,33-34,36-39}

Research shows that these generalizations are based on international publications dating from the 1980s. These publications were in turn based on a 1983-estimation by the WHO. There has been no confirmation of the 200 000 number for South Africa, nor has research findings been revised.\textsuperscript{3,33-34,36-39}

Determining the true number of traditional healers in South Africa by way of a membership count of traditional healer societies seems problematic, because there is not a single non-compulsory body that registers all the traditional healers as a single group. Official registration with the newly created statutory body, the Traditional Health Practitioners Council of South Africa (THPCSA), is not compulsory or fully active at the moment.\textsuperscript{40,41}

Many of the traditional healers are organized and “licensed” by one of more than 200 unofficial organizations or associations. These organizations are sometimes registered under the Companies Act as a business entity, but not as a professional body reflecting professional training. Depending on the strength(s) and criteria, membership of organizations range from ten to thousands, with some traditional healers based regionally, provincially or operating nationally.\textsuperscript{38-46}

Numbers calculated based on membership numbers can clearly not be accepted as correct unconditionally for various reasons.\textsuperscript{41,47} The African Technology Policy Studies (ATPS)\textsuperscript{47} furthermore reports that many bogus traditional healers obtain healer status and contribute to the 200 000 or more.\textsuperscript{41,47}

Pretorius\textsuperscript{41}, in referring to the claim of 200 000 traditional healers in South Africa and the ratio between the population and traditional healers of 1:200, calculated that of the 80 000 persons practicing traditional healing in Gauteng Province, only about ten per cent are “bona fide healers.”

This means, if the 200 000 number is true, at most only 20 000 qualify as “real” traditional healers in terms of Pretorius’ criteria\textsuperscript{41}. ATPS\textsuperscript{47}emphasizes further that in the era of HIV/AIDS and other hard-to-treat diseases, bogus traditional healers take advantage for the purposes of self-enrichment. It further seems as if there is a contingent of bogus healers from East and West Africa who are counted into the assumed 200 000 South African traditional healers. Even the adjusted number of 20 000 as possible \textit{bona fide} healers seems to be incorrect and an over-estimate.\textsuperscript{41,47}
A further confounding factor in the determination of the present numbers of traditional healers in South Africa is that the names traditional health practitioner, traditional healer, traditional health doctor, medicine man or doctor are misleading. These are quasi-names that activists, propagandists, researchers, the government and the public commonly use, clearly without understanding its real meaning and boundaries. These general quasi-descriptive names make it possible for many people (possibly even more than the 200 000) to pride themselves on being “traditional healers,” as various researchers already demonstrated.  

The name traditional healer is clearly a non-specific name for various non-medical workers in South Africa. It is a mixture of indigenous spiritual, cultural and social work types, totally outside the definition of practice, training or domain of any of the officially registered health professions, like nurses, dentists, medical doctors, etc. A comprehensive study of career literature describes the different kinds of traditional healers by many names. Some names are: diviners, herbalists, traditional birth attendants or midwives, traditional surgeons, medicine men, bonesetters, sorceress, spiritual healers, home caregivers, traditional advice counsellors, holistic healers, faith healers, traditional doctors, spiritual practitioners, priests, psychic healers, traditional health clerks, and diagnosticians.  

These various classifications, names and definitions make it virtually impossible to identify a group of persons who work in traditional healing as a single group that can be counted and described as traditional healers.

A statistical and descriptive approach shows that only 2.2 per cent of traditional healers have some form of tertiary education or have attended tertiary training. This level of qualification makes the traditional healers comparable to the minimum level of schooling for the registered or regulated healthcare professions before they start academic or in-service training, namely the completion of the senior high school certificate (Grade 12). This means that only 2.2 per cent of the alleged 200 000 traditional healers in South Africa are on a “comparable school-leaving level” with modern healthcare practitioners before training, especially the medical doctor, with whom they are competing in the healthcare market and for a healthcare position. This means that according to the classification of the ATPS (read together with the Pretorius criteria), at most 4 400 (2.2% of the alleged 200 000 traditional healers) really qualify as persons who are ready to embark on some kind of training in terms of final school-leaving certification. They then still lack the three to eight years of tertiary training that other healthcare practitioners receive depending on their fields.
If tertiary training is taken as a criteria, the chances are good that the estimated 2.2 per cent of the ATPS\textsuperscript{47} can be halved to 1 per cent \emph{bona fide} healers or 2 200 in number with an assumed tertiary training of three or more years compared to the claim of 200 000 traditional healers.

The above findings correspond better with the present total registration membership of more or less 4 000 members of the allied professions in South Africa. They only reached this number after nearly 40 years of regulation (compared to 4 400 estimated “real” traditional healers). If only the present number of practising registered homeopaths, naturopaths and phytotherapists are taken into account after nearly 40 years of regulation, namely more or less 1 300 (compared to an estimated 2 200 \emph{bona fide} traditional healers with some form of tertiary education), it still corresponds more or less.\textsuperscript{43,49,52}

Aforementioned gives a good indication of the low number of registrations of \emph{bona fide} traditional healers that can be expected in terms of the Act if strict registration rules are followed.

The number of traditional healers in South Africa can further be calculated by combining Pretorius\textsuperscript{41} research with the manifestos of various traditional healer organizations.

Among all the organizations for traditional healers, only the Traditional Healers Organization (THO) openly declared that they have 29 000 members. They also give a clear reason as to why this number is 29 000 and not the massive numbers of the other organizations, namely that they use selection criteria for registration. As such, the leaders of the THO\textsuperscript{42,53,54,55} claim they have sifted through the massive group of bogus healers with the following training and registration requirements: (a) training of two years and mentorship, as well as a further three years of part-time guidance and support; (b) to become a member of the THO already practicing traditional healers have to attend a one-day workshop to be introduced to the THO activities and a five-day workshop on traditional primary healthcare; (c) persons who want to join the THO as healers must also produce a reference of good character.\textsuperscript{41,42} If the criterium of “three years or more tertiary training” is made applicable to the 29 000 THO members by using the ten per cent calculation of Pretorius\textsuperscript{41}, only 2 900 remain. This outcome is in line with the estimated 2 200 of this study, based on the one per cent criteria of the ATPS\textsuperscript{47}. The 2 900 seems to correlate to a certain extent with the 2.2 per cent of the ATPS\textsuperscript{47} guideline that reflects 4 400 healers. However, the General Household Survey for the period 2008 to 2013 shows a far lower presence of traditional healers in the South African healthcare sector.\textsuperscript{39,56,57} It also reflects a constant decline in the use of the traditional healer since 1990.\textsuperscript{39,56,57}
For the years 2008 and 2013 the average utilization of the services of traditional healers was respectively 1.2 per cent and 1.4 per cent of the Black population of South Africa.\textsuperscript{7,39} When the 2004 – 2013 statistics are translated to the use, availability and presence of healthcare providers in the community, it means that for the 39 000 medical doctors registered in 2013, there were only 390 traditional healers in practice.\textsuperscript{7,30,39} This is in line with the 1.4 per cent average use for 2011, which reflects only 546 traditional healers in practice against 39 000 medical doctors in terms of the percentage comparison.\textsuperscript{7,30,39}

It is clear in terms of the above statistics that there cannot be more than about 4 400 credible South African traditional healers. It can be as little as 390. The number of 4 400 is a fraction of the untested, alleged 200 000 or more traditional healers reflected in the general literature on the South African traditional healing.

2.6.2 The ratio of traditional healers versus medical doctors is 7:1 in South Africa.

One of the misleading practices that resulted from the claim of 200 000 traditional healers practising, is the habit to compare this untested number of an alleged 200 000 traditional healers with the total number of registered modern healthcare practitioners, especially medical doctors, in South Africa (see addendum B1). This is not only done to support the claim that there are 200 000 practising traditional healers, but is also offered to support the assumption that there is an enormous need for their healthcare services and medicine. Some researchers have indeed referred to this anomaly and contradiction in the available research and have asked for cautiousness with interpretations. This warning was clearly ignored by most of the researchers involved in the promotion of the traditional healers after 1994 in the new South Africa. The result is falsified research that is used to strengthen the belief that there are large numbers of traditional healers that overshadow established medical doctors and that they are central role-players in the South African healthcare sector.\textsuperscript{38,41,47,48,51}

The claims described above put 200 000 traditional healers against 30 000 medical practitioners, resulting in a ratio of 7:1 in favour of the traditional healers. [More recent statistics on Africa as a whole reflects a ratio as high as 80:1].\textsuperscript{37,38,49,58-63}

The above ratio supports the view that there is a great demand for traditional healers.

Research shows that these numbers have in fact been manipulated to reach this outcome and that there is actually an enormous group of registered healthcare professionals providing services to the public. Even if the number of 200 000 was true, very few of these persons meet even the most basic training requirements. This number of 200 000 traditional healers should also be
compared with the total number of registered healthcare professions (like psychologists, pharmacists, doctors, allied professionals, dentists, nurses, welfare practitioners, etc.) in South Africa, not only general practitioners. All the registered practitioners have statutory recognition and advanced scientific and practice training in healthcare that are of a much higher standard than that of the traditional healers. The total number of registered healthcare professionals reflected for 2013 to 2014 was 259,025. The number of medical doctors was 38,236, dentists 5,560, qualified nurses/midwives 124,045, allied auxiliary practitioners 43,584, practicing pharmacists 4,562, psychologists 6,019, social welfare practitioners 8,078 and non-practicing health practitioners 28,941.

The stated ratio 7:1 for South Africa is clearly inaccurate and changes dramatically when the total number [all types registered with the Health Professions Council (HPCSA) and other Health Councils] of registered health professionals is taken into account. This makes it 200,000 traditional healers (all types, seeing that the term traditional healer can include more than 20 kinds of traditional healers, although the Act only defines four) against 259,025 registered healthcare professionals (all types). The ratio dramatically changes to 1:1 (259,025:200,000), with even a small favouring of the registered or regulated healthcare professionals.

This outcome contradicts the strong demand for traditional healers as measured by proportional numbers when compared with all the registered healthcare practitioners.

When the groups are compared in terms of the total grouping of 259,025 qualified health professionals with the more trustworthy number of 4,400 credible traditional health practitioners (representing the 2.2% with some tertiary training in terms of the APS guideline), the ratio is in favour of the registered or regulated healthcare professions with a ratio of 59:1. When the 2,200 credible traditional healers (as calculated with the ATPS/Pretorius criteria), who are assumed to have more than three years of tertiary training, are compared with the number of registered general medical practitioners of more or less 38,000, the ratio is 17:1 in favour of the medical practitioners.

The national statistics of the General Household Survey of 2013 also provide insight into the possible number of credible traditional healers in South Africa. The survey statistics for the period 2004 to 2013 (10 years) reveal that when asked what healthcare professional people prefer to first contact in times of medical emergency, only an average of 0.2 per cent preferred a traditional healer, compared to 22.0 per cent who prefer to contact a medical doctor. This reflects a ratio of 1:110 or a percentage comparison of only one traditional healer for every 100 doctors available in terms of the 2004 to 2013 statistics.
The above findings disprove the claim that there is a great need for traditional healers. This removes one of the motivations for the promulgation of the Act.

2.6.3 The majority of South Africans regularly consult traditional healers

One of the many claims put forward by the activists and politicians in the application to parliament was that traditional healers play a valuable role in healthcare and that the majority of South Africans consult traditional healers regularly (see Addendum B2). Many writers and researchers claimed that as many as 80 per cent of the total South African population regularly make use of this service. Current literature still reflects the view that the majority of South Africans regularly consult traditional healers; some even puts the figure higher as 80 per cent of the population. An overview of the literature that makes reference to the 80 per cent consultation rate in South Africa uncovers more than 50 authors who use this statistic. This percentage was already old news in the 1980s.34,36-39,43,49,52,61-63,68-75

The various arguments, motivations and views on frequent use of traditional healers in the application in 2007 to promulgate the Act No 35 are supported by information (untested) collected by an internal committee on traditional healing in 1992, a national steering committee in 1993, a provincial standing committee on health in 1997 and a National Council of Provinces committee in 1998.1,76-81

The Department of Health (DOH) also held a series of road shows during 2001 to 2002 to gather information (again untested, based on hearsay) on the need for traditional healers in the future healthcare of South Africa. Political and cultural agents and drivers who focus on traditional healers as an extraordinary Black tradition and custom that must be conserved and not so much as necessary and prominent healthcare practitioners, were strong role-players in the early hearings to regulate traditional healers.1,76-81

The question is prominent: is the assumption that the majority of South Africans regularly consult traditional healers true or false? Also, is the view that 80 per cent of South Africans regularly consult traditional healers true or false?

The fact that the Act has not been fully enacted and that no statistics are available on consultation and practice rates from registered traditional health practitioners means that a statistical conclusion requires another approach. The Traditional Health Practitioners Council (THPC) and medical funds and schemes do not collect any data on traditional healers either.82
Contemporary data on the use and popularity of traditional healers in South Africa reflects a different picture than the arguments, statements and views offered in the 1990s to motivate the regulation of traditional healers through the Act.\textsuperscript{82,83}

First, statistics on South African traditional healers show that the visits to traditional healers are mostly “culturally” driven instead of medically needed, in contrast with the claims of lobbyists in their projection of traditional healers as a kind of medical doctor. The findings of a South African study show that of the 19, the most popular “medical preparations” used by traditional healers, as many as 17 (89.4\%) are used exclusively for shamanism (like enhancing luck in love and careers, appeasing ancestors and avoiding disastrous situations).\textsuperscript{47,58,84,85}

Scholars are furthermore of the opinion that if South African studies were more specific in questioning and used a question that asks about ancestor worship or even about issues of a more psychological nature, it would long since have been revealed that traditional healers are not as often consulted for physical (medical) conditions. This would reveal the true role of spiritual healers.\textsuperscript{85}

Second, various other South African studies between the period 2003 to 2013 reflect that traditional healers play an insignificant role, not only in the healthcare sector, but also in community life. It is reported that since 1990, there has been a constant decline in traditional consultations in South Africa.\textsuperscript{86}

One of these South African studies in 2003 showed that the monthly consultation rate of traditional healers made up 5.2 per cent of public expenditure on medical services. A further consultation rate of 6.0 per cent was reported for faith healers. This means that 11.2 per cent in total of the public made use of the traditional healers in 2003 in some way in South Africa. In 2003, 88.8 per cent of the population did not make use of the traditional healer at any way.\textsuperscript{39,84,85}

For the period 2008 to 2011, the use of traditional healers by Black South Africans decreased dramatically to only 1.2 per cent in 2008 and 1.4 per cent in 2011, measured as consultations per month. In terms of monthly visits, visits to traditional healers are rare (0.02 visits), especially compared to the utilization rates of public sector clinics (0.18 visits) and hospitals (0.09 visits). When comparing traditional healers’ popularity and use with that of medical doctors, the ratio for traditional healers was very low (1:110). It seems that Black households prefer the use of public health facilities that offer a variety of regulated healthcare practitioners (mostly medical doctors and nurses). For the period 2008 to 2011, 81.3 per cent did not use traditional healers, nearly the same as the 2003 finding of 88.8 per cent.\textsuperscript{39,86}
A 2013 South African study reflects that only 0.1 per cent of the respondents selected traditional healers as the first choice of healthcare practitioner in the consultation line. The 2013 consultation rate for medical practitioners is 21 per cent. This again reflects a low ratio for traditional healers against medical practitioners (1:220). For the period 2004 to 2013, the average consultation rate for traditional healers was only 0.2 per cent, compared with an average rate of medical doctors of 22 per cent (ratio 1:110). When the percentages of consultation of traditional healers and medical doctors are compared, the use of traditional healers is less than 1.0 per cent, reflecting an insignificant presence of traditional healers in the general South African healthcare context.

This 1.0 per cent average for 2004 to 2013 contradicts the 5.2 per cent of the 2003 studies, but confirms the 2008 and 2011 studies that showed only between 1.2 per cent and 1.4 per cent use of traditional healers in South Africa.

Another way to calculate the percentage input of traditional healers in the present South African healthcare system is to compare them with allied professions in terms of practice income and the sale of products. Both traditional healers and allied professions practise mostly outside formal healthcare, with overlapping interests in a dual healthcare system. The allied professions have been officially regulated for more than 30 years. Positive numbers for this sector would surely predict positive outcomes (but possibly an over-estimation) for traditional healers.

The total income generated in 2005 in South Africa by allied professions was R97 033 651, while that of medical doctors was R4 402 206 860. This represents an income of only 2.2 per cent for allied professions compared with the income of medical doctors. When only the consultation income of the two groups is calculated for 2005 (allied professions R62 073 868; medical doctors R3 633 078 604), the ratio is less than 1 per cent. In terms of dispensing income (allied professions R34 959 868; medical doctors R769 128 256) the ratio is less than 5 per cent. These outcomes indeed reflected that allied healthcare practitioners have a very limited role in South African healthcare. Given the results for the allied professions, traditional healers will most probably be limited to an insignificant role in formal healthcare in terms of income analysis.

Researchers also claim that in certain areas in South Africa (which they describe as the poorest areas), a larger number of the population use traditional healers. In practice, it seems that this data only apply to small segments in the rural areas of South Africa. These areas are isolated and there is an absence of proper medical facilities and staff.

Of the alleged 80 per cent of poor people in the formal sector of South Africa, only 5.2 per cent of the public really contact traditional healers for medical preparations and medical treatments. This
means that as much as 94.8 per cent of the total poor population of South Africa do not use traditional healers. These “poor” users have declined dramatically since 2003 and in 2011 as much as 98.6 per cent did not use traditional healers.47,56,58

The general assumption that 80 per cent of South Africans visit the traditional healer before they see the modern practitioner and that this must be seen as a clear vote of more confidence in the traditional healer, was, without offering any statistics to confirm it, indiscriminately used by activists, politicians and traditional healers to have traditional healers regulated in 2007 by the Act.34

This general view reflected in literature seems to be based on a 30-year-old statement that 80 per cent of the world population makes use of traditional healers, used originally in a book Traditional Medicine and Health Care Coverage, published in 1983 by the World Health Organization (WHO).39 The research of Wilkinson39, p.320 identified that Robert Bannerman, a WHO regional advisor and manager of the traditional medicine programme of the WHO at that time, wrote in this publication: “that in many of these developing countries primary healthcare devolves on the healer, herbalist, traditional midwife, and other traditional practitioners and that these are the health workers that offer services to the disadvantaged groups that total about 80 per cent of the world’s population and have no easy access to any permanent form of healthcare.”

Notwithstanding the fact that Bannerman failed to offer any evidence, reference or other data to support his statement, it became distorted over time, as with many other statements and claims on traditional healthcare. It became a driving force of its own, including in South Africa. He surely did not intend the statement as such at that time. He was focussing on access to healthcare. The fact that WHO reports re-use information without retesting one report before use in another report has caused this issue. Bannerman’s non-specific remark about healers, herbalists, traditional midwives and other traditional practitioners that can offer services to the disadvantaged groups, which total about 80 per cent of world’s population, has undergone a change in meaning in later publications. Wilkinson84, par. 2 alludes to the fact that it resulted in the claim that: “80 per cent of the population depends on traditional medicine, or that 80 per cent of the African population uses regularly traditional medicine to help meet their healthcare needs, or that traditional medicine is the first source of healthcare for about 80 per cent of the population in developing countries.”84

“Other WHO publications (like Promoting the Role of Traditional Medicine in Health Systems: A Strategy for the African Region 2001-2010 and Traditional Medicine Strategy 2002-2005), also adopted this distorted reading of the original version by Bannerman,” as Wilkinson84, par. 2 shows in her research. This claim has remained the primary source for researchers due to the credibility
of the WHO, without anyone asking about the trustworthiness of research facts or data. This circled out, Wilkinson\textsuperscript{84} shows, to other important opinion makers, such as BBC News, which carried an article in 2013 about traditional healers in South Africa, claiming that these healers remain the first point of contact for physical and psychological ailments for about 80 per cent of the Black South Africans.\textsuperscript{84} The same can be said for the South African Medical Journal (SAMJ) in 2012 when it suggested that in some cases, 80 per cent of South Africans use traditional medicine to meet their primary healthcare needs.\textsuperscript{84}

Multiple researchers have quoted this percentage in their articles, presentations and books and applied it to the populations of Southern Africa. It became a convincing argument, although untested, in favour of regulating traditional healers in terms of the Act as valuable and sustainable healthcare practice for South Africa\textsuperscript{37,49,56,84,88}

The argument that the majority of South Africans regularly consult traditional healers is unsubstantiated. The commonly quoted South African consultation rate of 80 per cent is also unsubstantiated and deceptive. This 80 per cent is an outdated 30-year-old statement that is irrelevant in terms of the utilization of South African traditional healers. It is clear that an untruth was used in the motivation of the promulgation of the Act and statutory recognition of the traditional healers in 2007. The information was flawed and distorted. \textsuperscript{34,86,87}

\textbf{2.6.4 The fees that the traditional health practitioner charges are generally lower than that of the medical practitioner}

The cost of healthcare is a matter of concern for the public and the authorities. When a new healthcare provider enters the healthcare market, specifically the private sector, it is crucial to know if the fees will be affordable, especially when that service provider claims to be able to offer a far less expensive service than the competitors. The cost of healthcare is of great importance in South Africa, especially for the poor sector of the country. The post-1994 government has exerted itself to offer an inexpensive healthcare service to the poor (see Addendum B3).

One of the main pleas to regulate the traditional health practitioners claimed that these healers offer an affordable health service to the poor, especially in isolated rural areas, because the fees and costs of practice are generally less expensive than those of the medical practitioner. This plea was strengthened by the argument that there is a shortage of public and private health practitioners who work in these areas, while public services like clinics and hospitals fail to offer much needed healthcare. \textsuperscript{34,50,56}
However, literature shows that the fees and costs are almost the same for the two groups, notwithstanding the higher training of the medical practitioner versus the lack of formal medical training of the traditional health practitioner. The only clear difference between the two kinds of healers is the patient-friendly payment system of the traditional health practitioner. This group follows a far more flexible approach regarding payment than the medical practitioner does. It is not necessarily always more affordable, but it does in general accommodate the personal financial needs of the clients. To make payment easy, especially in the rural areas, the traditional health practitioners accept payments in cash or in livestock. In addition, some of the traditional health practitioners also follow a policy of “no payment for no cure.” Undoubtedly this guaranteed outcome offered by the traditional health practitioner holds financial benefits for the clients and lowers the end costs.\textsuperscript{34,47,50,56}

Some traditional health practitioners also follow a policy of once-off payments for multiple services over a period of time. This minimizes the stress on the poor client’s cash layout every time he visits the traditional health practitioner, either for a specific ailment or for various ailments treated over an extended period. Undoubtedly such a comprehensive service where the healer down-prices his final charge, benefits the clients. These practices can contribute to the perception of low costs.\textsuperscript{34,47,50,56}

Conversely, researchers also show that the traditional health practitioner’s fees and costs can directly contribute to the higher living costs of poor households. This may be a reason why the use of traditional health practitioners is declining when free and effective government health services and qualified healthcare practitioners are available. Researchers point out that visits to a traditional health practitioner can cost up to 10 per cent of the household expenditure per annum. In this context, a cost of 5 per cent is already a heavy burden on a poor family’s budget, while a cost of 10 per cent and above can be catastrophic and can result in even more severe poverty.\textsuperscript{34,47,50,56}

The simultaneous use of the traditional health practitioner and the medical practitioner can double the medical expenditure of poor households. This double use can wrongfully lead to a perception that the medical practitioner’s healthcare service is expensive, while the costs of the traditional health practitioner is not at all brought into consideration as a contribution to the problem. One furthermore has to take into account that the traditional health practitioner’s treatment does not always bring healing and that the patient may ultimately be forced to incur extra costs for modern healthcare treatment from the medical practitioner. Not only does this negative outcome render the service of the traditional health practitioner less inexpensive, but the extra costs and emergency services rendered by the medical practitioner to rectify the traditional health
practitioner’s mistakes, erroneously reflect on the medical practitioner’s income system as normal services rendered, heightening his fees and costs profile.\textsuperscript{34,47,50,56}

Gumede\textsuperscript{34} provides a different perspective on the traditional health practitioner’s “no payment for no cure” and “once-off payment practice” as described by researchers.\textsuperscript{34,47,50,56} He mentions that there is a “small retaining fee,” a “doctor’s fee for opening his doctor’s bag” for the first consultation at the traditional health practitioner. Regarding the final amount to pay for treatment, Gumede\textsuperscript{34} says that: “the fee was well-known to all and sundry; it was a beast – an ox or a cow.” This means that the once-off payment for traditional health practitioners can be up to R5 000 or more. This amount is surely not a low fee or an inexpensive cost to the patient. In this instance it must be noted that this was the fee for 1990, excluding inflation of a period of twenty six years.\textsuperscript{34}

This expensive fee structure of the traditional health practitioner is also confirmed by the study of Flint and Payne\textsuperscript{89} in the Eastern Cape. They investigated traditional health practitioners’ treatment of HIV/AIDS with uBhejane (a rhino-muti cure). In 2006 this cost R300 per visit, with rates as high as R2 000 if animal sacrifices are included.\textsuperscript{89}

Modern hospitals and medical facilities situated in urban areas are sometimes difficult to reach for many poor people, especially in deep rural areas. Journeys involve long distances, poor public transport facilities and expensive taxis. With vast areas of land and poor road and transportation systems, many people have to travel long distances on foot to reach medical help. Once they arrive, they are often required to wait in queues for hours as the shortage of clinics and resources causes overcrowding. Medicines are not always readily available at district clinics, even at hospitals. Patients are often not informed about the cause of their illness or given any information about it at all. This not only leads to personal and health insecurity, but to patients remaining uninformed about preventing or handling specific ailments. This situation creates hostility among poor patients and results in them staying away from public healthcare facilities. Alternative medical help and services, like that of the traditional health practitioner, become their only alternative.\textsuperscript{43,56}

These situations promote the services of traditional health practitioners, not necessarily because they offer trustworthy and beneficial medical services, but purely because they are the only type of health service immediately and locally available. The government’s failure to offer an effective medical system in the rural areas has, especially in the past, created a false impression of the traditional health practitioner’s services are cheap and effective. The sub-standard health system of the government and the extra costs it brings for the poor when they have to use the traditional health practitioner as an alternative has nothing to do with the medical practitioner and the fee
structure. This failed official healthcare system and incorrect reporting in research do injustice to the South African medical practitioner as a professional. The use of these one-sided perceptions of the medical practitioner’s fee structure in literature is misleading.\textsuperscript{31,90,91}

The fact that the South African government fails to train enough medical practitioners also reflects badly on the medical practitioner’s fees and cost structure. This can relate to their salary in public service or the income generated from their private practice. The shortage in medical practitioners has led to increased demand for their services, which pushes up their income. This failure to train enough medical practitioners is evident from the fact that the eight local medical schools only deliver 1 200 medical practitioners annually compared to a much poorer and under-developed Cuba’s output of 50 000 medical practitioners per year. Medical training is therefore another government problem that is now projected onto the medical practitioner’s fees and costs.\textsuperscript{92-94}

It must, however, be acknowledged that the South African government has done much since 1994 to bring free and inexpensive healthcare to the poor in rural areas. More than 1 600 clinics have been built or upgraded and been staffed with qualified practitioners while free healthcare is available for children under six and for pregnant and breastfeeding mothers. The pre-1994 healthcare system, in which hospitals were run on apartheid principles to benefit Whites, was also successfully abolished, giving a much higher healthcare allocation to the poor. More than 260 000 healthcare professionals are now available to patients in some form. The district nurses furthermore play an important role in rural communities. These developments minimize the role of the traditional health practitioners and their services in rural healthcare. This lower demand for their services seems to force them to lower their fees to make a living.\textsuperscript{36,46,58,59}

Regarding the role and public use of the traditional health practitioner, it is important to note that a 2008 South African study shows that the use of traditional health practitioners has declined in tandem with an increase in the wealth of patients: the poorest patient group had an average of 0.03 visits the previous month to the traditional health practitioner, while the wealthiest group had 0.002 visits to the traditional health practitioner.\textsuperscript{56}

As reflected above, the use of the traditional health practitioner is considerably lower than the use of public sector health services, which includes the medical practitioner working in the system (0.18 to 0.09 visits). Visits to public sector health services also declined with an increase in socio-economic status as wealthier patients make considerably more use of private health services. It seems that the older age groups (median age 35 years) make more use of traditional health practitioners than the younger and more modern groups (median age 23 years). It is clear that the new Black middle class (and upwards), who is surely in a better financial situation and are
less traditional, is moving into the use of modern medicine, leaving the traditional health practitioner out in the cold.\textsuperscript{56}

In 2003 there was a general use of less than 12 per cent of traditional health practitioners by limited segments (poor) of the population with less than 10 per cent for medical work, while in practice less than 2 per cent of the total population used the traditional health practitioner specifically as a healthcare practitioner. Since 2008 statistics collected countrywide have shown that the use of the traditional health practitioner, especially by Black South Africans, was never more than 2 per cent of the total population. Official research also reflects that since 1990 there has been a constant decline in the use of traditional health practitioners, basically because they are increasingly being replaced by better and cheaper public healthcare services and practitioners. This confirms that public use of the health services offered by the traditional health practitioner is insignificant and not always as inexpensive as claimed.\textsuperscript{34,43,56} The arguments about the lower fees and costs of the traditional health practitioner, when compared with that of the medical practitioner, are not really accurate.\textsuperscript{49,56,84}

This study cannot conclude that the fees and costs of the traditional health practitioner are lower than that of the medical practitioner. There seems to be hidden political agendas behind the rhetoric of the lower fees and costs of the traditional health practitioner compared with that of the medical practitioner. The promulgation of the Act and the statutory registration of the traditional health practitioners in 2007 seem to be a primary goal in this distorted argument. It is clear that the medical practitioner is not too expensive, below standard or provides inadequate health services. The perception of low fees and costs of the traditional health practitioner is kept alive with a political agenda to maintain the traditional health practitioner as a cultural and political institution in new South Africa.\textsuperscript{95-98}

2.6.5 The traditional healers are the true owners of traditional medicines in South Africa

Literature postulates that traditional medicines form an important part of modern South Africa’s healthcare system (see Addendum B4). The belief is that the traditional healer and traditional medicine are a close unit, with the traditional healer as the true owner of traditional medicines and the sole manufacturer of traditional medicines. This viewpoint forms a strong motivator in the ANC regime’s final decision to promulgate the Act and to regulate the traditional healer. Various studies also postulate that the growth and development of traditional medicines are restricted by the pharmaceutical industries and other role-players like the medical fraternity.\textsuperscript{41,49,56,58,76-78,99,100}
There are many more role-players who are active in today’s traditional medicines manufacturing industry than the traditional healer and the traditional fraternity. The literature on traditional medicines fails to reflect the true meaning of traditional medicine in modern South Africa and to whom it really belongs. Literature offers no in-depth analysis and understanding of the various regulations of the Act and of the definitions traditional philosophy and traditional medicines to identify true ownership of traditional medicine.41,49,56,58,76-78,99,100

There is a clear differentiation between the dominant (real) traditional medicine and the inferior pre-modern traditional products of the traditional healer. The title deed or card and transport of traditional medicine are held by various public and private institutions and other entities, not at all by the traditional healer fraternity.

South African literature on traditional healing offers opinions, statements and views on the excellence of traditional medicines and states that a dramatic evolution in traditional medicines is currently underway here and worldwide.41,49,56,58,76-78,99,100

Regarding the assumed intellectual property rights of the existing traditional African medicines (TAM), it is postulated that the power of the multinational pharmaceutical industry, together with cultural imperialism, had marginalized it. It is specifically alleged that the lobbying of pharmaceutical cartels after 1994, together with hostile attitudes of medical doctors and the medicine regulators, are in the process of destroying the South African traditional healer’s unique traditional medicines.40,41,42,44,54,100

Even the good name of the Medical Research Council (MRC) is selectively abused to promote the existence of a “South African traditional medicine culture” by reflecting global information, which is clearly applicable to the supplementary/complementary medicine (CAM) industries and not to South African traditional healing (pre-modern, self-made concoctions), as part and parcel of the TAM of the traditional healing fraternity.44

From the many opinions and views offered in the literature, a clear profile emerges of the excellence of the traditional healer’s medicines and of an excellent traditional health service offered by the traditional healer through these medicines. It is further alleged that traditional medicines and the traditional healer form a unique, unity that is unbreakable and inseparable from the traditional healthcare fraternity, and as such that traditional medicines are the exclusive domain of the traditional healer. For the propagandists of traditional healing, a differentiation among the kinds of traditional medicines does not exist. The objections of the regulated allied health professions and the supplementary/complementary manufacturers that traditional
medicine is their domain and that there is a misconception in the minds of the traditional healing fraternity and their propagandists to see and to reflect their traditional products (muti/concoctions) as similar to (real) traditional medicine, are bluntly ignored.\textsuperscript{40,42,44,49,54}

At present the true ownership of traditional medicines, with or without the prefix \textit{real}, is a point of debate. Especially the conception that traditional medicines are the sole domain of traditional healing is controversial and should be addressed.

Indigenous traditional medicines were surely a strong competitor of the European traditional medicine when last-mentioned made its appearance at the Cape of Good Hope in 1652. On the other hand, is it clear that it was the indigenous traditional healers’ own actions that kept them from becoming role-players in the mainstreams of healthcare. They insisted on a spiritual orientation and did not address their lack of medical training. The Second World War brought a further change to scientific healthcare. It shaped a health complex to which indigenous traditional medicines were not a partner for a long time. They remained stuck in the dimensions of the healthcare of the 1600s.\textsuperscript{49,52}

Since the 1960s traditional healing, the traditional healer and traditional products slowly moved to the foreground again, not because of an urgent need for it, but because it had become a political determinant and pivot of certain streams of thought and practices on African culture and – rights. This movement gained momentum with the advent of the post-1994 political dispensation and was supported not only by the traditional healing fraternity and sympathetic politicians, but also strongly by the activists and propagandists in favour of traditional healing. These groups offered various opinions and statements regarding the absolute needs and benefits of the traditional healer’s (indigenous) traditional medical products.\textsuperscript{49,52,76,101}

Thorough research shows (as already described) that most of the supporting evidence mentioned in articles, books and other reports, including the belief about the existence of the exclusive TAM of the traditional healer in South Africa, is based on wrong WHO information that created misleading beliefs, statistics and superficial thinking more than 30 years back. A cleansing of these churnings and falsities should have occurred when the Act was considered. \textsuperscript{39,49,52,76,84,101}

The belief of the existence of the exclusive TAM of the traditional healer in South Africa should be addressed as true or false, specifically the \textit{present ownership of traditional medicine in South Africa}.

In South Africa \textit{traditional medicine} is a definition that encompasses the wide definition \textit{traditional philosophy} of Section 1 of the Act. The whole Act is based on the definition of \textit{traditional philosophy}.\textsuperscript{101}
*philosophy*, which reads “indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and the use of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation whether supported by science or not, and which are generally used in traditional health practice.”¹

First, the description of traditional medicines in the Act already reflects ignorance among the traditional healing fraternity with respect to their understanding what traditional medicines truly mean. Second, there is a public acknowledgement by the Act itself in its definitions that there is at present no indigenous traditional medicines culture that is unique to traditional healing in South Africa. This absence of an established indigenous traditional medicines culture and intellectual property rights are reflected in the following wording: “traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not.”¹ This kind of phrasing in an Act’s definition is nothing else than Dark Middle Age mythology-writing and story-telling.

The absence of an existing *indigenous traditional medicine culture* is further reflected by Section 1 of the Act’s superficial and insufficient description that traditional medicine is only “an object or substance used in traditional health practice.” This proves the absence of a proper traditional medicines culture. The main intention of the Act is to regulate and to guard the interests of traditional healing, yet there is nothing concrete in evidence to lay claim to an established science of traditional medicine or to demonstrate with any written documentation the fraternity’s intellectual and property rights on certain traditional medicines that are in use as scientific matter or profit, either by them or the established healthcare.¹

This shortcoming in the Act is again covered up with the inscriptions “traditional medicines communicated from ancestors to descendants and without written documentation;” empty clichés that have no standing as the truth.¹

The fact is that the traditional fraternity arrived on the scene in 2007 with the Act without any proof of an existing history and culture of traditional medicines. Claims of the intellectual and property rights on traditional medicines held by the traditional fraternity are myths that had become truths within a new policy of political correctness that no one dares to challenge. Notwithstanding this embargo on the truth, various writers would not be silenced and they classify the traditional healer of South Africa’s “medicines” under the single name *muti*. It is known that muti can include substances varying from human organs, human blood and nail-clippings to potions from herbs and plants.¹⁰²⁻¹⁰⁴
Other literature on traditional medicines also classifies the traditional “medicines” of the South African traditional healer as pre-modern, indigenous concoctions that include rare lizard fat, snake skin, sun burnt beetles and spiders, lion lard, dried crocodile liver and baboon testicles and substances from plants. These are clearly not medicines that will be listed and protected by the South African health authorities as exclusive traditional health intellectual property or used by the regulated health professionals. 34,41,105

There is currently a clear and a specific differentiation between what is often called traditional medicines (also known as real traditional medicine or complementary/supplementary medicines) that are manufactured by complementary manufacturers and the traditional products (also named medical concoctions, magic medicines or muti medicines) of the traditional healer. Complementary medicine manufacturers have their own quality control separate from the Medicines Control Council (MCC), while the products mixed by traditional healers are not subjected to any quality testing or scientific standards. It is clear that the description of what is regarded as traditional medicine is misleading and incorrect in the Act. The definition of traditional medicines included in the Act refers to the mixtures prepared by traditional healers (or medical concoctions or muti). 49,74,101

A critical analysis of the pharmaceutical safety of traditional products shows that the safeguard included in the Act’s definition of traditional medicine, namely that such medicine “does not include dependence-producing or dangerous substances or drugs,” is not a guarantee that the traditional healer’s untested traditional products (muti and concoctions) are free from dangerous components. It lacks MCC certification as well as registration on the Pharmaceutical Product Index (NAPPI), which are used as the only guideline by pharmacists and doctors for prescriptions. The danger of these muti products is confirmed by the fact that the same government that promulgated the Act had to establish two state-centres to combat muti-poisoning. 44,49,106

There is a misconception that the two entities, traditional healer and traditional medicines (last mentioned in reality a subdivision of supplementary medicines) form one unit in the traditional healthcare context. To the contrary, traditional medicines have their own domain, totally separate and independent from the traditional healers and their pre-modern methods and products. The traditional healer is indeed dependent on pre-modern traditional products for an existence as a supernatural healer. Pre-modern, supernatural traditional products are clearly not included in the definition of modern-day traditional medicines. 49,74,101

Pre-modern traditional products (concoctions and mutis) are used by traditional healers solely because plants and herbs (and animal substances) are plentiful, easy to gather and because it is
easy to manufacture traditional medical products with little cost and know-how, while legal rules that govern the manufacturing, use and sales are also non-existent for traditional healers. It is furthermore popular with traditional healers because healers are too untrained and too under-educated to understand the manufacturing, working of and the safe prescription of regulated medicine.\textsuperscript{100,107,108}

Traditional healers also have a negative impact on biodiversity due to their self-manufacturing of medical products. There is already an 86 per cent shortage in plant and animal sources for their products. Especially the use of certain herbs in their treatment of HIV/AIDS led to serious damage to biodiversity, while the smuggling of the protected plants and animals for use in traditional products is very destructive. Research also shows that 51 per cent of healers ignore plant reservations in their plant gathering. The effect on biodiversity is enormous if the statistics about their use and output of traditional products per annum are true. Consider for instance that 1 500 tons of medical products are sold at the Durban markets alone every year, that 20 000 tons of indigenous plant materials of 771 species of plants are used and that 128 million causes of traditional medicine treatments are prescribed.\textsuperscript{40,44,47,101}

Limited success (untested and unconfirmed) with the use of pre-modern traditional products by traditional healers to treat mild diseases shows that the traditional healer does not have an extraordinary healing ability with the exclusive use of self-made traditional medical products. Real traditional medicines do have potential, but then clearly apart from the traditional healer’s pre-modern manufacturing and use of traditional products. The only contribution of their traditional medical products (concoctions) in the past and even today is as “spiritual medicines.” This helps the traditional healer to survive and to remain in the present position of supernatural and mystic treatments for a limited group of South Africans.\textsuperscript{100,107,108}

In essence, “real” traditional medicine, which is associated with and is similar to or is part of supplementary/alternative medicines, is nothing else than natural or phyto-medicine, meaning medicines made from plants. Modern medicine in South Africa does have branches in the use of herbs and plants, like the naturopathy, homeopathy and phytotherapy. Even the modern medical practitioner makes use of these types of real traditional medicines, seeing that as much as 30 per cent of the world’s drugs come from plants, but only after it is reworked and refined pharmaceutically and scientifically. In the modern medical practice, the use of these real traditional medicines are verified by scientific cause-and-effect guarantees, based on reworking and refining and biochemical tests and retests before it is made available for use. This is far removed from the pre-modern traditional products, described wrongly in Section 1 of the Act as traditional medicine. The traditional healer’s refusal to put his primitive, self-made traditional
products (muti or concoctions) on trial for testing and retesting and to obtain scientific certification to ensure its safety, confirms their inability to manufacture safe and effective traditional medicines.\textsuperscript{34,49,52,71,100,108}

Researchers\textsuperscript{3,37} are correct when they state that the growing international popularity of traditional medicines signals a new era for traditional medicine in South Africa, but are totally led astray when they see traditional medicines as the same as muti or pre-modern traditional medical products, and the traditional healer as the primary role-player in this context. Indeed, the traditional healer is not even a secondary role-player. The traditional healer’s negative role with his medical concoctions outweighs any advantages and benefits to scientific medicines. His traditional products (muti) are health dangers to the public.

It is clear that real traditional medicines are being taken care of by various public and private pharmaceutical and scientific institutions and other entities in their focus on developing most of the real traditional medicines into a pharmacopoeia of sound modern medicines and to integrate it with the user-bank of modern medicines. Real traditional medicines are not owned at all by the traditional healers of South Africa. This inclination is far removed from the traditional healers and their pre-modern, supernatural practice, beliefs, habits, customs and dangerous medications. The argument put forward in 2007 of the traditional healers as the true owners of traditional medicines was false. It was a politically driven argumentation of activists, propagandists and lawmakers of the ANC regime to legalize traditional healing through the Act and to provide statutory recognition for the traditional health practitioners.\textsuperscript{38}

2.6.6 The estimated annual incomes of South African traditional healers as generated by their practices and sales of their pre-modern traditional products are between R2 billion and R3.4 billion

During the debates leading up to the promulgation of the Act, those in favour claimed that the manufacturing and selling of traditional medicine (TAM) by traditional healers has an enormous financial impact on the gross income of the country (see Addendum B5). South African researchers on traditional healing claimed that TAM specifically generates an annual income of between R2 billion (R2 000 million) and R3.4 billion (R3 400 million), roughly an average of R2.7 billion (R2 700 million), from the sales of traditional health products and mixtures by South African traditional healers. The idea was also promoted that the traditional healers offer a widespread indispensable medical service, specifically through their medical and health products, which contributes to a further R1 billion (R1 000 million) or more in income.\textsuperscript{43,52,109}
A more recent study on the economics of the traditional healers’ pre-modern medicine trade in South Africa alleged the existence of 68,000 full-time practicing traditional healers, 63,000 plant harvesters and 3,000 street vendors of traditional plant materials. The study postulates that this group possibly generates an annual income of between R2.9 billion (R2 900 million) and R3.4 billion (R3 400 million).109

Traditional healers also claim that there is an extraordinary demand for their traditional healing in the form of treatment and pre-modern traditional medicines (muti). As showed earlier in this chapter (see subdivisions: 2.6.1 to 2.6.3 of this Chapter and Addendums B1 to B2 for detailed descriptions), they falsely allege that approximately 80 per cent of South Africans regularly consult traditional healers for treatment with their traditional health medicines and that this has led to a contingent of 200,000 or more practicing traditional healers in South Africa, already making this claim suspicious. 43,52,109

Traditional healers purport that the massive impact of their service delivery in South Africa leads to 128 million traditional prescriptions to 26.6 million customers annually. They claim that 133,000 persons work in the South African pre-modern traditional medicine trade, generating an income of between R2 billion (R2 000 million) and R3 billion (R3 000 million) or more per year, which would represent 5.6 per cent of the national health budget. They furthermore allege that 72 per cent of Black South Africans use traditional medicines as part of their daily lives. They also claim that this need is constantly growing and that all the various social and economic classes of Black South Africans use and prefer traditional medicines and products. 43,52,109

As previously indicated, it seems that a misconception was created in South Africa about what traditional medicines really are and who the specific manufacturers and sellers are. (For a detailed description see subdivision 2.6.5 of this Chapter and Addendum B4). No differentiation is made in literature between the real traditional medicines offered and marketed on the South African retail and commercial market and those (muti) prepared by traditional healers. Some traditional medicines are available from well-established outlets like pharmacies, health-shops and statutory registered allied traditional healthcare professionals. These medicines have to adhere to a formal manufacturing and scientific foundation, while traditional healers rely on self-made, pre-modern and untested indigenous mixtures. This lack in differentiation and scientific foundation has clouded the true ownership of traditional health and medical products as viewed and understood under the definition Traditional African Medicines (TAM). This vagueness also obstructs the compilation of a profile of the income generated by the various role-players in their practices by manufacturing and selling traditional medical and health products. The result is a misrepresentation of sales statistics in South African literature on traditional healers and their self-
made health products and untested mixtures, giving the traditional healers a misleading position of importance in the healthcare sector. This erroneous thinking served to award the traditional healers professional healthcare status in 1994. 43,52,109

Current South African literature generally reflects an erroneous classification of who the true manufacturers and sellers of traditional health and medical products are, and what “traditional medicines” really means. This has led to an acceptance of South African traditional healers and their untested and risky health products and mixtures based on a misconception that they are the true manufacturers, sellers and owners of TAM. The most prominent role-player in the manufacturing and selling of traditional medicines and the true income-generator seems to be the formal South African industry of CAM. This comprehensive, well-established and prominent medicines industry has been manufacturing and marketing South African traditional medicines for decades. They do this scientifically as a viable and sustainable enterprise. In comparison, there are the traditional healers’ unscientific practices and the medical products that they manufacture and sell outside of the formal healthcare sector. There is no sound foundation and substantiated evidence in the literature to confirm traditional healers’ primary role as manufacturers, developers and sellers of the modern-day South African traditional medical and health products. They fail the test of a scientific, viable and sustainable role player in the field of South African traditional healing and TAM. 43,52,109

Trustworthy literature on the TAM trade of South Africa is lacking. Most of the studies are old, while the more recent ones only focus on certain segments of Black South Africans and specific areas, such as the Black trade in traditional medicines at markets like those in Durban and Johannesburg. An in-depth analysis shows that most of these researchers used small samples of 30 to 400 persons, lacked applicable information-gathering methods, and make generalizations regarding the demand for and use of traditional medicines and services by more than 45 million of South Africans. There is a measure of political opportunism and subjectivity, specifically after the new political dispensation of 1994. Most of these studies fail when it comes to the requirements of statistical inference about the wider South African population from the information on their samples.109-111

Conclusions are strongly based on generalizations, assumed and estimated outcomes and the repetition of untested literature. The studies lack sound scientific research and statistical foundations to offer a proper view and understanding of the trade in traditional medicine for the country as a whole. It seems that some of these research approaches and justifications for the findings, presentations and estimations border on the reckless manipulation of facts to promote South African traditional healing and to suit the thinking of propagandists and politicians in the
new RSA. The inappropriate extrapolation of trends in healthcare politics, needs and education has undoubtedly led to ridiculous conclusions on traditional healing.\textsuperscript{109-111}

What is more, there is a lack of objective identification and recognition of the legal role players responsible for the manufacturing, marketing, selling and scientific development of modern-day traditional healing practices and medicines in South Africa. The wider history of South African alternative medicines and healing is blindly ignored in the post-1994 political dispensation (it was indeed totally ignored in the promulgation of the Act), specifically the role of complementary/alternative traditional medicines and the statutorily recognized allied traditional healers. These include homeopaths, naturopaths, phytopaths and ethnopaths, who became the official guardians of the development and promotion of the modern South African traditional medicines by the 1980s. Propagandists and government supporters of the outdated South African sector of traditional healing, an insignificant remnant of old African religious traditions and customs, ignore the more scientifically based field of alternative medicines.\textsuperscript{109-111}

CAM and its practitioners had already taken over the roles and positions of the South African traditional healers by 1960. CAM is one of the main role-players in the development, management, marketing and steering of modern TAM in South Africa. This became official in 1982 with the promulgation of the Allied Health Practitioners Act (63 of 1982), notwithstanding superficial efforts by politicians and propagandists of the outdated South African traditional healing sector to revive traditional healing in new South Africa with the Act.\textsuperscript{52, 109, 112}

It is important to understand what the meaning of traditional medicine is for South Africans before one can understand the issue around the possible optimal maximum income of TAM for 2015/2016 as generated specifically by the South African traditional fraternity. Only after such insight can the real role players in TAM be identified and the income matter appropriately evaluated.

Three definitions of traditional medicine are available:

- **World Health Organization (WHO) global definition**: “Diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or to prevent illness.”\textsuperscript{43,49,100}

- **WHO Africa definition**: “The sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or social imbalance,
and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing.”

- The Traditional Health Practitioners Act (22 of 2007). The WHO Africa definition is more or less the same as that of the definition of the Act, as reflected in its description traditional philosophy, read together with the definition traditional medicine: “indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice.” In this context traditional medicine “means an object or substance used in traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness; or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-beings, but does not include a dependence-producing or dangerous substances or drug.”

The above definitions give the impression that TAM is exclusively the intellectual property of the South African traditional health fraternity, including the indication that they are the true generators of an annual income that ranges from of R2 billion (R2 000 million) to as much as R3.4 billion (R3 400 million). This impression is strengthened by two prominent guidelines: first by the view that modern traditional medicine in South Africa is something distinct from CAM and must therefore be treated as an exclusive entity with exclusive health and medical products and income. The second guideline is the WHO interpretation that traditional medicine is a way of protecting and restoring health that existed before the arrival of modern medicine and that these approaches to health belong to the traditions of each country, handed down from generation to generation, notwithstanding the fact that it is pre-modern, unscientific and outdated.

The WHO furthermore states, without offering evidence to support it, that CAM is not part of a country’s own traditions. In terms of the above interpretation, CAM seems to fall outside this TAM uniqueness, but as said, without sound arguments or facts to support it.

South African and other global literature contradicts the above “uniqueness” of TAM as an entity separated from CAM. CAM is indeed TAM in South Africa; it incorporated and replaced African indigenous medicines successfully in South Africa over time. The official registration of phytotherapists (as well as homeopaths and naturopaths) as allied health substitutes for the traditional herbalists of indigenous healing are excellent examples of this transformation of TAM into CAM. The comprehensive definition of complementary medicine furthermore confirms that African traditional medicine was successfully incorporated into the supplementary health fraternity.
in the 1980s. TAM is indeed a limited subdivision (represented by phytotherapy, naturopathy, homeopathy) of the allied health fraternity in South Africa and is managed as such in terms of the Allied Health Practitioners Act (63 of 1982).\textsuperscript{52,112}

The complementary medicine definition of the act reads\textsuperscript{52, p. 65}:

Complementary Medicine means any substance or mixture of substances, originating from a plant, mineral or animal, which may be, but is not limited to being classified as herbal, homeopathic, ayurvedic or nutritional, used or intended to be used for or manufactured or sold for use in complementing the healing power of a human body or animal body or for which there is a claim regarding its effect in complementing the healing power of an animal or human body in the treatment, modification, alleviation or prevention of disease, abnormal physical or mental state, or the symptoms thereof in a human being, and may encompass substances or mixtures of substances used in the disciplines generally referred to as Western Herbal medicine, African Traditional medicine, traditional Chinese medicine, traditional Dutch medicine, homeopathy, ayurveda, aromatherapy and food supplementation.

The identification and classification of TAM in Africa (and therefore also in South Africa) is that it is a sub-medicine, one of many, inside the greater medicine group of CAM.

The above definition nullifies the exclusive global and African WHO definitions and the definition of the Act on African TAM, as well as the clause of “medicine before the arrival of modern medicine.” The definition extends the Act’s clause\textsuperscript{114, p. pari.nyi}: “traditions of each country, handed down from generation to generation,” to CAM. CAM, its practitioners and its customers are therefore full members of the South African “traditions of traditional medicine.” CAM’s traditional medicine knowledge and culture are undoubtedly, as described in the Act as TAM, also “handed down from generation to generation.”\textsuperscript{114} Indeed, this CAM definition takes TAM directly into the health/medical sciences of the 20\textsuperscript{th} century under the guardianship of the CAM fraternity.\textsuperscript{46,112} It modernizes and strips the pre-modern African TAM of its supernatural and unscientific contents and past (the outdated remnants that politicians and propagandists of traditional healing at present try to revive in South Africa). On the other hand, it also nullifies the assumed existence of a dual system, with TAM and CAM as equal, but independent role-players in health care in South Africa (this immediately makes a theoretical estimation of TAM, based on CAM-findings, such as this study tries to do, questionable).\textsuperscript{40,42,43,48}

A comprehensive and sound infrastructure for the scientific manufacturing of traditional health and medical products is lacking at present. In South Africa, there are presently between five and ten manufacturers that are active in some way in the manufacturing of traditional health and
medical products. However, they all lack research standards and quality control. These groups seem to be supported by a further 50 to 100 laissez faire manufacturers of traditional products in the country, also lacking quality control. These products are manufactured, stored and sold mostly in unhygienic conditions. They do not conform to the pharmaceutical industry’s good manufacturing standards or to the minimum standards prescribed for MCC certification of medicines.43,52,109

In an effort to understand the current sales of traditional medicines and products in South Africa, two different but opposing role-players must be taken into account:

- Traditional health practitioners, as defined and described by the Act, with their self-made and home-made, untested pre-modern traditional health/medical products and mixtures, versus
- market orientated local CAM manufacturers and distributors of traditional medicines and products with their high standard of industrially produced, tested and evaluated medicines that adhere to the pharmaceutical industry’s good manufacturing standards.

Literature reflects that a total amount of R68 102 000 (R68 million) worth of homeopathic medicines, R141 573 000 (R141 million) worth of herbal medicines, R11 075 000 (R11 million) worth of aromatherapy medicines, R889 066 000 (R889 million) worth of nutritional supplements and R238 550 000 (R238 million) worth of health foods were sold in South Africa in 2003. It clearly shows that the only “unique” African medicine sold was African herbs to the value of R2 000 000 (R2 million). This was less than 1 per cent of the total homeopathic sales, already reflecting the insignificant sales of traditional health products in South Africa. The majority of the sales were from various traditional products (overwhelmingly under the classification CAM) of local or foreign origins, but clearly outside the manufacturing domain of South African pre-modern traditional products.43,52,109

Furthermore, the R2 million worth of African herbs sold were not sold by traditional healers themselves, but by various modern outlets, like food stores, pharmacies, supermarkets, chain stores and toiletry discounters inside the CAM fraternity.38,43,52,109

These African herbs, as indicated, were primarily marketed and manufactured by a modern and well-established CAM group, namely the Health Products Association (HPA), with 114 members and other role-players. There is also no indication in support of traditional healing that these products (herbs) were sold only to indigenous or Black South Africans in rural areas (the main working domain of the traditional healers) or for use in traditional rituals that involve traditional healers as such. These products were sold to the broad public, outside the traditional healers’
practice domain and could therefore have been used in the same way as Western and Chinese herbal preparations. This finding throws doubt on the view that traditional products and CAM can be seen as equal partners in the health market. Indeed, it seems that the traditional health products, as manufactured and marketed by the traditional healers, only occupy a fraction of the market and sales of that of CAM.\textsuperscript{41,43,52,109}

The mass selling of traditional products by the CAM fraternity outside the traditional healers’ practices and markets is in line with research\textsuperscript{26} that postulates that 90 per cent (89.7\%) of traditional products are sold outside traditional healers’ practices. This means that only 10 per cent of the traditional health products prescribed in the traditional healers’ practices can be traced to and associated with traditional healers’ activities and can therefore be seen as income generators. This not only clarifies the low input and use of the traditional healer services and their untested home-made health and medical products, but foregrounds that TAM (excluding the traditional healers’ health and medical unscientific products and mixtures) is indeed part of the South African CAM.\textsuperscript{43,109,111} It also nullifies allegations that the need for the pre-modern health products of the traditional healers by Black South Africans is growing and that there are approximately 30 million users of pre-modern traditional medicines and that its sales represent 5.6 per cent of the national health budget.\textsuperscript{111}

The fact that African herbs represent only 1 per cent or R2 million of the total sales of CAM products emphasizes the insignificant role that the untested traditional products and mixtures really play in the formal, organized CAM and TAM. One can safely assume that the traditional healers’ total sales of their medical products, marketed through their unorganized outlets and limited pre-modern practices, could be at most only 10 per cent of all the formal sales of homeopathic products and in value the same or less than the R2 million sales in African herbs for 2003. The 2015/2016 theoretical estimation (including inflation) can therefore be at the utmost R300 million for the traditional healers’ income.\textsuperscript{43,109,111}

This outcome does not support the alleged general income of between R2 billion and R3.4 billion. This R300 million outcome (a tenth of the alleged income of R3 000 million reflected in literature) seems a very acceptable, even optimal theoretical estimation for the total sales of traditional healers’ health products and mixtures for 2015/2016.

Another insight can be gleaned from the sales of homeopathic products. Literature reflects that the total sales of homeopathic products was R68 102 000 (R68 million) in 2003/5. In terms of the growth compensation, this R68 million can be as much as R10 billion (R10 000 million) for CAM in 2015/2016. In theory, the pre-modern traditional products could also generate R68 million in
terms of the 2003/5 CAM statistics, or R10 billion in 2015/2016 if the 50:50 relationship between traditional healing and CAM is true and can be accepted.\textsuperscript{43,109,111} As seen with the above finding of only a 10 per cent market share by the traditional healers’ health products when compared with CAM, one should be cautious of the possible 50:50 relationship. Various other factors also seem to nullify this 50:50 interpretation.\textsuperscript{41,43,52,109,111}

Here it must be noted that homeopathic products (TAM/CAM) include many products outside the scope of the traditional healers’ health and medical self-made products. Also, these sales figures as reflected in the literature were achieved by means of an intensive marketing system.\textsuperscript{52} This R10 billion as a possible theoretical sales figure in 2015/2016 for traditional products requires further refined calculation, analysis and short discussion.

Research only confirms the existence of between 300 and 400 informal and informal traditional (concoction) product outlets (described as “muti-shops” in the literature and managed from sidewalks) for traditional healers in South Africa. There are only between five and ten manufacturers of traditional products, with a further 50 to 100 laissez faire manufacturers. This infrastructure is only 3 per cent of that of CAM. This low number of outlets and manufacturers undoubtedly limits the production and sales of the pre-modern traditional products and mixtures of the traditional healers in the country. It surely dramatically lowers the estimated R68 million sales of homeopathic products (CAM) for 2003/5 as equal to the traditional health products, as previously indicated. This situation surely also affects the growth compensation of R10 billion (R10 000 million) for the pre-modern traditional products of the traditional healers estimated for 2015/2016. In terms of only 3 per cent against the 100 per cent marketing and sales ability of the CAM, the theoretical estimation of R68 million of 2003/5 and the R10 billion (R10 000 million) of 2015/2016 for the CAM, the sales figures for the pre-modern health products and mixtures of the traditional healers can only be about R2 million for 2003/2005 and at most R0.4 billion (R400 million) for 2015/2016 respectively.\textsuperscript{109}

This finding of R400 million is in line with the above finding that the pre-modern traditional health products of the South African traditional healers as reflected in the sales of African herbs, can be no more than R300 million for 2015/2016. These two outcomes contradict the alleged incomes of between R2 billion (R2 000 million) and R3.4 billion (R3 400 million) as true incomes generated by the traditional healers.

The possible financial impact of traditional healers’ self-manufactured medical products on health care and the use and purchase of their self-made products by the public was calculated by
analysing the medical schemes expenditure on CAM for 2005. The analysis specifically focused on payouts to dispensing allied and allopathic health professionals.\textsuperscript{43}

Data reflect that the total dispensing income (selling in the CAM practice) generated by the allied professions in 2005 was only R34 959 793 (R34 million) against the total dispensing income of R7 150 193 033 (R7 150 million) for all the registered healthcare practitioners. From this total income, the pharmacists' income was R6 381 064 777 (R6 381 million) and medical practitioners' income was R769 128 256 (R769 million). Sales of CAM (R34 million) in practice by the allied practitioners is only 1 per cent of the dispensing income of the pharmacists and allopathic practitioners together.\textsuperscript{43}

These data reveal that the allied professions fail to make the same financial impact by dispensing their CAM as the medical practitioners do with MCC medicines. The same can theoretically be said for traditional healers' sales of their self-made traditional products, since it has already been indicated that the traditional healers' health products only represent 10 per cent of the homeopathic sales and that the traditional healers marketing only represents 3 per cent of that of homeopathy. The traditional healers' annual dispensing income for 2005 could not be R34 million or R5.1 billion in 2015/2016 as theoretically estimated for the allied professions. The assumed financial impact of R34 million by the alleged 200 000 traditional healers in South Africa is furthermore disproven by evidence of fewer than 5 000 credible traditional healers practicing in South Africa. This finding is further supported by indications that not more than 14 out of a 1 000 of the South African population make use of traditional healers and that there is a continuing decline in demand for the services of traditional healers since the 1990s in South Africa. This negative trend in terms of diminished demand is further aggravated by a lack of professional and organized consulting and marketing facilities, as well as medical fund backing. All these negative factors minimize the presence of traditional healers in the health care sector. This reflects a total market presence of 1 to 3 per cent in the South African health care sector, meaning an income of not more than R1.2 million in 2005 and an income of R0.15 billion (R150 million) for 2015/2016.\textsuperscript{43}

When the allied professionals' dispensing income for 2003/5 is specifically compared with the medical practitioners' dispensing income, the discrepancy is still enormous: R769 128 256 (R769 million) for the medical practitioners compared with R34 959 793 (R34 million) for the allied professionals. This reflects only a 5 per cent allocation to the allied professionals.\textsuperscript{43}

The above negative position of the allied professionals reaffirms the low incomes generated by the traditional healers in their practices and through sales of their pre-modern traditional health products. An income of R150 million seems to be optimal as reflected in the previous paragraph.
Indeed, the above data show that even the allied health professionals, who constitute a statutorily recognized health science group that has been regulated for more than 30 years in South Africa and who promote themselves very strongly, can still not make significant in-roads into the general health care sector's income with their CAM alone. This is notwithstanding its well-developed scientific foundation and intensive self-marketing through pharmacists and organized points-of-sale. The South African traditional healers, with their total lack of an established infrastructure (for instance formal consulting rooms, statutory status, medical aid-support), the constant decline in the demand for their services and their unscientific pre-modern health products and mixtures, are surely far worse off.

The maximum incomes of between R150 and R400 million for South African traditional healers per annum as reflected thus far by the calculations of this study at this stage seem to be plausible.

The financial incomes of traditional healers and their health products can also projected by calculating their potential income. This can be calculated by looking at the income generated by consultations and the sales of their pre-modern and self-made health products and mixtures. Literature reflects the benefits paid out in 2005 by medical schemes to all regulated health practitioners as one comprehensive group. Medical doctors generated a total income (consultation and dispensing) of R4 402 206 860 (R4 402 million) against the total income of only R97 033 651 (R97 million) generated by the allied health practitioners. The allied health practitioners' income is only 2.2 per cent of that of the medical doctors.43

This reflects the unfavourable income position of the traditional healers in South Africa: it seems that they not only occupy at most between 1 and 10 per cent of the health care market, but financially also only between 1 and 10 per cent of the health care sector's income.

The above low-income dilemma of the traditional health fraternity is further pinpointed when the total income of the registered allied professions (seen as similar professions as the traditional healers) of R20 645 813 (R20 million) is compared with the medical practitioners’ income of R4 402 206 860 (R4 402 million) for 2005. This comparison shows that the allied sub-group’s income is less than 0.5 per cent of the medical practitioners’ income.43

This outcome confirms again that the traditional healers are undoubtedly insignificant role-players when it comes to income. They do not generate the extraordinary incomes claimed in South African literature.

The low-income of the South African traditional healers becomes even more clear when the total consultation incomes of all the allied health practitioners is calculated (consultation income
R62 073 868 or R62 million), compared to the consultation income (R3 633 078 604 or R3 633 million) of the medical doctors in 2005. In this case the income ratio between the allied and medical doctors is less than 1 per cent for the allied practitioners. [As already indicated in terms of dispensing income alone, the allied group only generated R34 959 793 (R34 million) compared to the medical practitioners’ dispensing income of R769 128 256 (R769 million). In this case the ratio is less than 5 per cent].

It is clear that the traditional healers, either through their services as healers or through the selling of their traditional products, at present do not occupy more than 1 per cent of the consultation market or the dispensing markets of the South African health care sector.

Another approach to calculating an estimated income for the traditional healers is the use of the allied health professions’ total incomes of 2003/5 as a guideline. The maximum total income per annum that the allied professions could generate in 2005 was not more than R97 million. Product sales produced a maximum of R34 million and consulting clearly did not generate an income of more than R62 million. The growth compensation reflects a potential total income of R14.5 billion (R14 500 million) in 2015/2016. The unorganized traditional healers could at most generate 3 per cent of that of the allied professions, which comes to an income of R3 million in 2005 and R0.4 billion (R400 million) for 2015/2016. The above finding of R400 million is in line with the findings so far of an annual income of between R150 and R400 million for the traditional healers, not between R2 000 and R3 400 million as alleged in literature.

The calculation of the consulting fees of only the homeopaths, naturopaths and phytotherapists (allied professions) of 2005 showed that the consulting income of the traditional healers in 2005 was not be more than R0.6 billion and the sales of their products generated more or less R1 billion, with the total practice income R1.6 billion. With the growth compensation, the total income of traditional healers for 2015/2016 could be as little as R240 million (R0.24 billion).

Although this amount of R240 million is R60 to R160 million lower than the amounts of R300 and R400 million for 2015/2016 so far calculated, it still is a good indicator that the traditional healers of South Africa do not generate incomes of between R2 and R3.4 billion (R2 000 and R3 400 million) per annum.

Another allegation that goes hand-in-hand with the unsubstantiated reflection of 200 000 and more practising traditional healers in South Africa is the allegation in South African literature that 80 per cent of South Africans consult traditional healers regularly and that this includes all the
social and economic levels of Black South Africans (see for more detail subdivisions 2.6.1 to 2.6.2 and Addendum B1). The claim of 80 per cent utilization and a growth in this trend must be tested to obtain a perspective on the true usage (in rand value) of the traditional healers’ pre-modern traditional products. For such an evaluation various South Africa Household Surveys between 2003 and 2013 can be useful.\textsuperscript{39,56,58,84,85,109}

In this regard research shows a constant decline in the use of traditional healers in South Africa from 1990 onwards. In 2003, it was reported that only 52 out of a thousand of the public consulted traditional healers monthly (with a further 60 out of a thousand of the public reporting that they seek care from traditional healers simply as faith healers for spiritual needs). This total of 112 out of a thousand means that approximately 90 per cent of the total population do not make use of traditional healers at any time, which contradicts both the claim of 80 per cent usage reflected in South African literature and the claim of a growth in the usage of traditional healers.\textsuperscript{39,56,57,84,85,109}

One report stated that for 2008 to 2011, the use of traditional healers by Black households was only 14 out of one thousand per month. Furthermore, the monthly visits to healers were very low (0.02 visits) compared to the utilization rates of public sector clinics (0.18) and hospitals (0.09). The least favoured provider to use when seeking health care was the traditional healer (0.1%) compared to the private medical doctor’s high rating of 243 out of 1 000. In total, 81.3 per cent of South African Black households used public healthcare facilities first, leaving a possible, although undefined, 18.7 per cent that can consult traditional healers. This finding not only nullifies the alleged 80 per cent usage often quoted in literature, but also the allegation that Blacks from the higher income and better educated groups are using traditional healers more and more. It also contradicts the claims that the preference of the poor Black population is traditional healers. What is more, it disproves the claim of the enormous income alleged in literature by the traditional healing fraternity.\textsuperscript{39,56,57,84,85,109}

A 2013 South African study reflects a preference rate for the traditional leader of only one out of 1 000 as the first choice health care practitioner against the preference rate of 210 out of 1 000 for medical practitioners. For the period 2004 to 2013, the average preference rate for traditional healers was only two out of 1 000 compared to an average preference rate of 220 out of 1 000 for medical practitioners.\textsuperscript{57,109}

An overview also reflects that of the Black households who do visit traditional healers, as many as 90 per cent of the visits are mostly culturally driven. This indicates that only more or less 10 per cent of the visits are for some kind of medical reason.\textsuperscript{39,59} It furthermore seems that 62 per cent of Black households, in terms of their traditional healing usage, use pre-modern traditional
products without the services of traditional healers.\textsuperscript{65} This clearly indicates a further diminished income for traditional healers.

The above statistical incomes of this study are theoretical calculations done with the single aim of offering insight and obviating confusion around the present-day statements in research on the incomes generated by traditional healers and their pre-modern health products. Such a descriptive and exploratory approach is the only available solution for data collection to make up for the total lack of research and official data on the incomes of traditional healers. This approach offers a "liberal" statistical model to test the trustworthiness of the many allegations, assumptions, generalizations and statements on the incomes of the South African traditional healers and to make theoretical conclusions.

The total possible maximum income of South African traditional healers as theoretically calculated and estimated in this study seems to be between R150 million and R400 million for 2015/2016. The mean income, based on the separate five calculated incomes (R300, R400, R150, R400 and R240 million respectively), is R298 million. Even these figures (individual and average incomes) in money value must be approached with caution, especially when read with the South African Statistics finding in 2013 that the consultation of the traditional healers by the public is almost non-existent when compared with their main competitor, medical doctors. Even when compared with the allied health professions’ incomes, the traditional healers’ incomes are insignificant.\textsuperscript{41,43,52,71,108,109}

This study rejects the claim that the South African traditional healers generate an annual income of between R2 billion (R2 000 million) to R3.4 (R3 400 million), roughly an average of R2.7 billion (R2 700 million). This average estimation of R2.7 billion (R2 700 million), which is based on unsubstantiated assumptions, is nearly a tenfold over-estimation of the average estimation of R298 million found by this study based on substantiated population statistics.\textsuperscript{41,43,52,71,108,109} The idea that the traditional healers offer a widespread indispensable medical service, specifically through their medical and health products, which contributes to a further R1 billion (R1 000 million) or more in annual income, is unsubstantiated.

The South African traditional healing fraternity generates at most an annual average income of R298 million (varying between R150 and R400 million).

The motivations on income offered in 2007 for the promulgation of the Act were undoubtedly politically driven and on sound facts. It forms part of a well-planned strategy to get the Act promulgated and the traditional healers recognized as healthcare practitioners in the country.
2.6.7 The traditional healer has a religious distinctiveness in modern-day South Africa

Classifications and identifications of the traditional healer as a priest, spiritualist, a seer and religious leader and religious practitioner, are supported by the descriptions and definitions of many researchers (see Addendum B6) 34,37,43,56,64,115-122

Essien121 describes the traditional healer as an intricate part of the Traditional (old) African religions. He continues to say that the act of healing by the traditional healer is divine and that the traditional healer’s healing acts are aimed at aiding humans to adjust to superstition, magic and religious actions and threats. Gumede34 sees the traditional healer and his healing process as an integral part of the African religious context and as a “gifted man of God”: a parallel to the modern religious minister and evangelist. The idiom of approach of the traditional healer for Gumede34 is, besides the social, political, economic and moral transformations and guidance, mainly a religious one. Boon122 defines the work role of the traditional healer as that of a priest-healer (meaning to heal spiritually or to restore health solely through spiritual actions).

The shortcomings of most of these classifications and identifications include questions such as how the traditional healer as a community religious figure/practitioner/leader represents a certain group of believers’ religious views and what his own religious learning, opinions and standpoints are. Furthermore, there is no written documentation on his doctrine and the way he administers his religious beliefs, besides the overall acceptance that his religious healing/practice is founded in the supernatural, the ancestors and afterlife and the fighting off of the evil witch. The impression is that as many traditional religious healers/practitioners, as many traditional religious ideologies/dogmas there are. They are a grouping of unrelated and un-ordained individuals without any uniform religious practice and belief, customs and traditions, religious buildings like churches, mosques and synagogues, congregations, a Holy Book, the Bible or Koran for religious teaching or religious training schools as commonly found in the Islam, Christian and Hindu religions. The Act and the subsequent Traditional Health Practitioners Regulations No 1052 (2015) only indicate a minimum entrance qualification of Grade 3 to study traditional healing, while the training and scope of practice of individuals in the category Divination in Traditional Healing of the entity Diviner is left undefined.1,34,38,41,100,105,119,121,122

The word “divination” can mean “foreboding, forecast, fortune-telling, prediction and soothsaying,” while diviner can mean “augur, bone-thrower, forecaster, predictor, soothsayer, witch-doctor and wizard.” It is only the words “divine” and “divinity” (that form no part of the definitions and descriptions of the Act) that can mean “religion,” “spiritual” and “theology.” This casts doubt on
the classification and identification of the traditional healer as a religious practitioner in South Africa.\textsuperscript{1,5,34,100,123}

The question is therefore: do traditional healers have, as is assumed by many researchers, a religious distinctiveness in modern South Africa? The fact that only between 1 to 1.3 per cent of people in South Africa visit the traditional healer as a religious practitioner or for spiritual rituals and the lack of a comprehensive written doctrine on traditional religious practices, customs and traditions, make answers on this question a priority.\textsuperscript{34,38,85,100,122}

Overviews of the role of the traditional healer in the South African religious milieu tend to associate traditional healers with the old traditional African cultures that are assumed still to be active today. These cultures are supposed to uphold the traditional healer’s religious distinctiveness. However, assuming that Africa is still an ancient, isolated continent stuck in the Dark Ages is misleading. Modern South Africans follow modern lifestyles, adhere to modern thinking and are modern in religious inclinations. The country includes a wide variety of religions and although some religious beliefs, customs and practices are still regarded as unique to certain areas/regions, it is in truth also shared by many Africans all over the continent. The fact that Africans have always been dynamic and adaptable to new circumstances, that they had contact through global economics, politics, ethnicity, modern education and communication, brought immense changes over the last 100 or more years. In South Africa Christianity (and Islam in northern Africa) became interwoven with Traditional African Religions and it introduces many changes to these religious beliefs, rituals and customs (and of course, brought a change also to Christianity and Islam). The similar way the monotheistic religions like Christianity and the Traditional African Religions characterized God made this interweaving easy.\textsuperscript{34,48,119-126}

To argue therefore that there are still thousands of religions in Africa, each with its own, unique, isolated and undisturbed systems and foundations that have remained constant over hundreds of years and that these religions sustain the traditional healer’s religious status as a priest, is false. Resistance to religious changes in modern Africa has been minimal. Arguments of 40 years ago are outdated and are misleading.\textsuperscript{124}

However, the outdated cultural thinking of 40 years ago has not been phased out in all cases and it has found a strong position in current religious-political inclinations. This results in the promotion of specific religious customs and habits. Current political and social interference and intervention by these outdated groups in society are plentiful; even by fundamentalist, small minorities with power and influence. This is a worldwide phenomenon and it is reflected in South Africa as well. In the 1960s, in time of grand apartheid, the ANC identified certain aims related to the promotion
of African culture when they should come to power. The regulation and statutory recognition of
the traditional healer and their practices, like religious actions, was executed, as promised in
1990s, with the Act. The African mindset, religion and lifestyle function inside a predetermined
African mould, fixed permanently many hundreds of years ago. Free religious thinking, doing and
lifestyle are not possible for Africans who still adhere to this view. Such a person feels that if they
move out of their old African mould into the modern world, they immediately lose their rights to be
an African or a Black.10,76-79,127-133

This imposing of the excellent qualities of traditional healing and the traditional healer as a
religious practitioner has been a priority on the mind of the ANC since the 1960s, although not
reflected in their various healthcare manifestos since 1955. An unquestionable must: to be
accepted as true and existing. A myth has become a truth for a certain group of leaders and their
followers; a misleading viewpoint, also reflected in time in the literature on the South African
traditional healer’s religious distinctiveness.34,48,121,122,127

The truth is that Europe has not been home to only Whites for a long time; Africa is no longer only
populated by Blacks. The chances are good that even the indigenous African languages (and
culture) are only maintained at present by the unmanageable aggravating life circumstances of
South African Blacks and that it will be replaced in 50 years by a global language(s), like
English.134 The same can surely be said of present-day South African religious cultures, habits
and customs.

Racial, cultural and social boundaries have fallen away long ago and the composition of some
South African families or units already includes a Black, African, White, Afrikaner or Creole
member or members, showing the out of date of a “unique” African or Black religious culture that
is housing religious practitioners via traditional healers.34

Yet the old African mould still exists in the mind-sets of small but strong opinion-forming groups
who are trying to reduce even the modern African/Black to a limited, dependent cultural role in
Africa. This “African Nationalism” clearly tries to re-enforce racism and concepts like the traditional
healer’s spiritual status, while pure culture classifications (like African, Black and White) are
increasingly neutralized in the new South African social order. Outdated racism and belittling
racial views that seek to divide and that deny independent thinking – and also new, modern
religious beliefs and the right to Western and other modern religious adherence – are insults to
the indigenous African/Black of the post-1994 South Africa.10,34,129,135-138
The above outdated utterances by “pure” African academics and politicians are clearly remnants of thinking of the old Traditional African Religions that people still today wrongly experience as traditions instead of as religion (what they see as tradition is indeed faith, although without formal creed or sacred texts). It is in this context that the traditional healer’s religious distinctiveness is falsely portrayed as true, especially by the Act. This is clearly an excellent example of how fixed and false cultural, political and religious exclusiveness can be used to serve the selfish political aims of leaders to the detriment of innocent and less fortunate people by using their beliefs on religion leadership like the traditional healer.\textsuperscript{135,138-140}

Many current African political leaders have lost track of the enormous religious, cultural and political changes that have taken place since the 1900s, but especially after 1994. The same can be said of the redundant role of the traditional healer as a religious practitioner in the modern African Society of South Africa. It is inappropriate for the Act to promote the South African traditional healer’s religious role and his religious distinctiveness.\textsuperscript{10,17,18,64,119,124,135,139}

Religion, like culture and lifestyle, is not a permanent or an isolated phenomenon; it is dynamic and constantly influenced by other groups’ thoughts, philosophies, know-how and behaviours. For South Africa it is far more: it is about Black Africans and White Africans, African religions and European religions, as well as White Westerners and Black Westerners and the essence of African-ness, which is no longer exclusively a thing of blackness or whiteness, but of humanity and holism. It is no longer old, pure African thinking, believing and living. \textsuperscript{10,48,122,129,138,140-142}

One can no longer speak of a pristine or a pure African and South African religion with “pure” African adherents (like the traditional healer and the pre-modern religious thinking and actions that accompany this). As said, Christianity has spread dynamically through South Africa over the last 100 years and has influenced the practices of the Traditional African Religions and has contributed much to today’s Indigenous African Religions. On the other hand, the African religions rituals, beliefs and practices have also influenced the Christian religious rituals, beliefs and practices immensely. The outcome is that indigenous Africans have started to practice a new African Religion, the Indigenous African Religion (an in-between), in combination with Christianity. It must further be noted that Christianity came to Africa long before it reached Europe. The influences of the Christian colonists and missionaries were only extensions of an already established Christian religion of 1 500 years in Africa. The result today is a synthesis or combination of indigenous and non-indigenous rituals, beliefs and practices. Therefore, the present-day Indigenous African Religions can be described as alloys of traditional value systems, imbibed by foreign religious beliefs, rituals and practices. This interaction between the South African religious spheres occurred to such an extent that it is imprecise to speak of a sole
indigenous or traditional African religious dogma per se, seeing as Christianity has not only become a dominant African religion (80%), but that it can be described as a Christian African religion, leaving behind remnants like the traditional healer.\textsuperscript{48,119,120,124,125,143}

Religion changes as it is affected by cultural, economic and political changes. This occurred all over South Africa and the phenomenon affected all races, not only the Blacks. Not even Whites, notwithstanding their efforts since 1652 (especially between 1948 and 1994 with legalized apartheid), could stop their racial, religious and cultural interaction and intermixing with Blacks. This interweaving was so intense, especially after the 1950s, that the new Christianity (the White/European Christian Religion re-instated by the colonists and missionaries the last 100 years) today forms 80 per cent (79.9%) of the total South African population’s religious inclination. The belief of a separate White Christianity versus a separate Black Christianity fails to survive. African Christianity has permeated the South African lifestyle, pushing out outdated and pre-modern religious beliefs in which the traditional healer was a religious figure.\textsuperscript{17,34,143}

These changes go much deeper; the indigenous African is not only a homo Africanus, but also a \textit{homo Modernist}. He is in some cases much more homo Europeanist then his White counterpart and expresses this in his daily life, especially modern religious beliefs that exclude the supernatural and the traditional healer as a needed spiritualist.\textsuperscript{17,122,144}

In terms of the enormous changes in religious orientations in South Africa that also had a direct influence on the traditional role of the traditional healer as a religious practitioner, the question is: what is the traditional healer’s role or capacity in the present religious context? The traditional healer’s activities are located at most in the African religions that can be divided in two groups, namely the Traditional African Religions (the old group, with little religious standing in today’s society, reflecting remnants like the traditional healer as a religious practitioner) and the Indigenous African Religions (the new group, but also with a diminutive role in South Africa), which adapted parts of foreign and modern religions, cultural and cognitive thinking and behaviour in which the traditional healer as religious practitioner does not play a prominent role.\textsuperscript{48,119,120,125,144}

From above two main groups, it seems especially the Traditional African Religions have become delegitimized by African governments because of their negative behaviour linked to witchcraft, ritual sacrifices and other illegal practices and which, as a group, is in a process of being forced out of the religious systems. The continuous position of the traditional healer as a religious practitioner is clearly in difficulty in this context. To evaluate the traditional healer’s position in this context, it is necessary to first determine today’s total adherents to African religions (\textit{traditional} and \textit{indigenous}).
Detailed data of African religious adherence is limited. The research by Pewforum\textsuperscript{145} shows that in 2012, traditional religions represented 6 per cent of the total world religion population. This group of 6 per cent includes African religions, Chinese folk religions, Native American religions and Australian Aboriginal religions.

The research indicates that the followers of Indigenous African Religions (including the Old Traditional African Religions has shown a dramatic decline the last 100 years (a total decline of 49.9\% in adherents). This decline seems to be in line with the phasing out of the old, Traditional African Religions which are referred in literature too as old, rigid or fossil religions with overwhelming unacceptable rituals, like witchcraft, bad magic beliefs, etc.\textsuperscript{48,124}

Regarding a South African perspective, it is reported that at the turn of the millennium an estimated 28.5 per cent of the population adhered to Indigenous African Religions (and animist believers), compared to 68 per cent Christians, 2 per cent Islam and 1.5 per cent Hindus. In 2010 the adherents of Traditional African Religions were 210 000 in South Africa, against a total population of more or less 50 million. This represents only a 0.42 per cent of the total population. This finding shows that Traditional African Religions has been all but phased out. \textsuperscript{48,143,145}

Furthermore, the 2012 South African Census\textsuperscript{147} reveals that in 2001, out of a 44 819 778 total population that indicated their religious adherence, 35 416 616 citizens were Blacks. With reference to their specific religious affiliations, only as few as 124 947 Blacks registered as adherents to Indigenous African Religions (a total of 801 Coloureds, 132 Whites and 22 Indians/Asians also indicated that they are adherents to indigenous types of African religions). This means that only as few as 124 947 out of 35 416 616 Blacks are still adherents to the African religions (including the Modern Indigenous African Religions). This represents only 0.35 per cent of the total Black population. This percentage is totally insignificant, especially the fact that more or less 80 per cent of the country's Blacks (as well as the total population), identify themselves with Christianity. The enormous decline in adherents to the African Religions\textsuperscript{48} is evident from the 0.35 per cent indicated in the 2001 census statistics as well as the Pewforum-finding\textsuperscript{145} of 0.42 per cent.

It can be assumed that very few of the 124 947 adherents are still pure believers in the Traditional African Religions (old) and in pre-modern beliefs, customs and rituals (including traditional healers as religious practitioners) that researchers use so often to profile the standing of true African religions.\textsuperscript{34,48,124,125,144,146,147} It is furthermore clear that the traditional healer and spiritual healing are not part of the modern African Christian Religion, but belongs to Traditional African Religions.\textsuperscript{148}
It is clear that the traditional healer of South Africa has become dislodged from the role as a religious practitioner or spiritualist over the years. Clearly, the new Indigenous African Religions do not have a place for him. They still manifest in the remnants of the old Traditional African Religions that play an insignificant role in modern South Africa, and they seem to still be in the minds of certain politicians with masked agendas. The traditional healer’s impact, even in the modern Indigenous African Religions, is minimal, seeing that even this group only represents between 0.35 per cent and 0.42 per cent of the religious believers of the total Black population (35 416 616). The traditional healer’s total input as a religious practitioner of only between a 1 per cent and 1.3 per cent consulting rate is also insignificant and correlates further with the low 0.35 per cent to 0.42 per cent of adherents to Indigenous African Religions in 2001. It reaffirms this “outcast” position as a present religion practitioner; the input of traditional healers in the religious life of modern South Africans seems more obstructive than constructive.\textsuperscript{65,147}

It is clear from the above that the role that pure African religions (including both the traditional and indigenous groups) and the traditional healer as a religious practitioner play in present-day South Africa, is minimal. Rituals, customs, practices and muti, which can be associated with witchcraft, demons, bad magic, witches and other negative or problematic behaviours and actions by the traditional healer, have become rare in global South Africa. It is limited to the Limpopo Province where it seems to be problematic and where traditional healers are still very active.\textsuperscript{102,104,149}

The South African traditional healer’s treatment can be in line with that of a religious practitioner or spiritualist, but is most probably closer to that of a pre-modern indigenous welfare caregiver. The true status of a trained and ordained priest, monk, religious minister or reverend is absent. The indistinctive role of the traditional healer as a religious practitioner in terms of his status as a diviner in the modern life of South Africans is confirmed by the finding that usage of traditional healers as diviners by the total population per 1 000 is only between 12 and 15. At most, this usage represents only between 607 041 and 758 801 persons and is, in terms of the established religion Christianity, insignificant. There is also no evidence of a documented religious doctrine underwritten by the traditional healer, be it in the past or present.\textsuperscript{85,147}

The preservation of traditional healers and their religious role in South Africa, as done by the Act and especially by the literature on traditional healing, seem to be politically orientated in the post-1994 context where political leaders and opportunistic politicians with masked agendas abuse traditional healers as a religious and cultural heritage that must be maintained. This unhealthy political climate is also abused by the traditional healers themselves to advance their own interests. The traditional healer with all the supernatural doings, is a pre-modern spiritual phenomenon with an ambiguous status, stretching back to Apollo’s oracles and wizards.\textsuperscript{1,3,5,6,7,50,72}
It is clear that the South African traditional healer is not a theological or religious entity as viewed and recognized in modern life. It seems as if the name religious practitioner, as with the misleading label of medical healer, derives from a misunderstanding by early colonists and missionaries regarding the true religious role of traditional healer in the pre-modern South African society. They are at most augurs, bone-throwers, forecasters, fortune-tellers, predictors, soothsayers, witchdoctors and wizards: an entity in line with the Act’s definition of traditional philosophy. This philosophy centres the supernatural, which is accompanied by fearful, unexpected, unpredictable and bad life-experiences that threaten everyday life, the afterlife with the ancestors playing a central role and witch-hunting and -finding. It is furthermore clear that the divination activities of traditional healers as defined in the Act can contravene the stipulations of the Witchcraft Suppression Act (3 of 1957).\textsuperscript{1,5,34,100,123}

With special note to the promulgation of the Act and the role of the traditional healer specifically as a religious practitioner, it must be mentioned that religion cannot and may not be factored into the law-making process (especially into healthcare), even if it is seen as fitting and needed by the country. South Africa has a secular Constitution, with a Bill of Rights that guarantees freedom of religion (as well as non-belief). There is also the Ethics Act (82 of 1990) that guides the correct and good behaviour and decision-making of the executive authorities of the South African state. Both the South African state and its government must always remain neutral in relation to religion and should not favour any specific religion or a group of believers.\textsuperscript{8,9,12,150}

With the Act, the state and the ANC government did not stay neutral: they favoured the Traditional African Religions and the traditional healer as a pre-modern religious practitioner with their official statutory regulation as a healthcare practitioner. They failed the Constitution and put indigenous South Africans back into a new apartheid (although now a religious and cultural one), where, through the Act, the present government (as they accused the pre-1994 regime of doing with the Dutch Reformed Churches during apartheid) formed an association with the traditional healer as an outdated religious group. At the same time, certain Black leaders belittle and degrade Black citizens with respect to their right to think and to live religiously free under the guise of an untrue and false neo-Africanism, one that includes a specific religion as prejudice and bias.\textsuperscript{8-18}

\textbf{2.7 THE ANC’S POLITICAL POWERBASE IS SEATED IN AND DRIVEN BY OUTDATED BLACK CULTURES, CUSTOMS AND TRADITIONS OF THE MASSES}

The ANC started as a liberation movement. Even as recently as 1991 the ANC refused to describe itself as a party, preferring to retain the description “national liberation movement,” representing various classes of the community. In contrast to most African political parties, the ANC’s
foundation was never cemented in a tribal orientation, but was built on a territorial basis (total South Africa) with the primary aim to appeal to, to seek and to attract groups and individuals that have their roots in the pre-colonial society and who are against Afrikanerism and Afrikaner dominance as it manifested from 1948.\textsuperscript{21,25} Welsh writes\textsuperscript{25, p. 34}: “Its supporters include all shades of opinion, from liberals to hard-line Stalinists; it declines to call itself a ‘socialist’ movement, but there can be little doubt that much of the ANC’s theoretical and strategic discourse has been conducted in a Marxist paradigm.” This intention goes deeper, namely to respect and to provide in their supporters’ individuals special needs, customs and traditions of liberation, regardless of whether it can be pre-modern and dangerous. The ANC has never really been successful with shedding its liberation colours. These outcomes are constantly reflected in its governance; corruption; political, economic and social wrongdoings; and its dictatorial decision-making and management. The current disintegration of the ANC as a political unity confirms this liberation foundation that lacks party integrity.\textsuperscript{21, 25}

In its present healthcare politics, liberation priorities and interests are rated far more important than national priorities and interests. This goes for short- as well as long-term planning and the implementation of solutions. The statutory regulation of traditional healthcare was an outcome of this fault-line of political thinking and governing, endangering and disregarding the healthcare and the civil rights of South Africans. This kind of behaviour occurred worldwide in other liberation movements when they obtained political power, like in post-Shah Iran, Nazi Germany, Sadam Hussain’s Iraq, Gaddafi’s Libya and even the post-1948 NP of South Africa. These regimes’ power abuses mostly ended catastrophically.

2.7.1 The Ill-considered Rights and Privileges of the Masses

One of the biggest problems since 1994 is the inability of the ANC as a liberation movement (which had to transition to a “political party” purely to satisfy the political and personal selfishness of its leaders) to observe the restraints and respect for constitutional rules that liberal democracy presupposes. The established rights of responsible citizens versus the assumed newly awarded rights of the masses of lower class and poverty-stricken ANC supporters in terms of the constitution comes into play. Healthcare rights, needs, traditions and customs are prominent in this regard. Sound arguments and planning in the delivery of these services are mostly absent in the ANC. Actions, legislation and strategies are emotionally, subjectively and politically driven, especially on cultural issues such as outdated South African traditional healthcare. The ANC has had to please its masses of voters, especially the lower income groups who assured it of future political empowerment. The rights of democracy can bring healthcare rights to every individual by means of one man-one-vote, but the individuals do not always know what good and correct
healthcare practices are. It is also doubtful if the ANC lawmakers understand it themselves.\textsuperscript{19,25,133}

It is important to know and to acknowledge this mental fault-line, as Palkhivala did when he wrote\textsuperscript{133}, p. 111: “… the thirst for freedom can never be quenched in the human breast. But the one-man rite is not enough to make a democracy meaningful. It is the aristocracy of calibre which must take to public life, however, distasteful it may be, because the success of democracy depends upon an informed citizenry, not on the participation of every inmate in the asylum.”

The shallow thinking of the ANC politicians on what it means to offer sound, responsible and correct healthcare to every of the South African citizens is evident from politicians’ intentions in politics in general. Palkhivala describes this devastating dilemma for the voters and citizens well when he writes\textsuperscript{133}, p. 77: “Power politics has been called the diplomatic name for the law of the jungle. How long do we want to run the circus from the tiger-cage? A reasonable solution can emerge from men of vision, wisdom and learning. It will not come from politicians who put their party and themselves before the State; and more concerned with votes than with welfare of the people, more interested in the short-term prospects of their own party than in the long-term future of the country.”

The above political instability and unpredictability in the ANC’s mind-set results from its liberation-inclination (which is reflected in its rule from 1994 to 2017). The party ignores the democratic and constitutional rights and sound and scientific healthcare rights and preferences of every good and responsible citizen in favour of the unsound healthcare preferences and requests of the masses in the name of “democracy.” Welsh describes this aptly when he says\textsuperscript{25}, p.37: “What characterised liberation movements... was the stress on unity, the rejection of partisan division as destructive of the new nation, and the illusion that an entire country could have a single purpose and accept a single representative to speak as the ‘mouthpiece of an oppressed nation’. Political parties operating in a democratic framework, on the other hand, do not pretend to represent a people or a nation, but specific constituencies.” This behaviour reflects back to Welsh’s earlier reference to a Marxist paradigm in the behaviour of the ANC; here specifically with respect to sound healthcare models inside a well-established healthcare system.\textsuperscript{25}

Regarding the ANC’s implementation of outdated cultural traditions, customs and habits like traditional healthcare and the traditional healer, is it important to note that its aim as political group from 1912 to 1994 was to oust Afrikaners and apartheid. It was their only focus. They had to collect “a people” or “a nation” as supporters and voters to execute this aim. This single intention led to the emergence of the ANC in 1912. It was prominent in the 1960s as the strongest Black (unofficial) opposition group, and after its unbanning in 1990 as the strongest Black party. After the 1994 election they had to meet their supporters’ needs, customs and traditions as their new
government. Many of these needs, customs and traditions are based on untested and controversial cultural claims, specifically the untested need of the general population for traditional healing.19

2.7.2 Another pre-1994 drive behind the plan to introduce traditional health into South Africa’s formal healthcare sector

It seems that another main driving force behind the recognition of the occupation of traditional health practitioner was to a certain extent also revenge on early discriminative White decisions, policies and politics related to African cultural beliefs, customs and habits, like traditional healing. Strong opposition from some sectors of the healthcare sector due to the danger that traditional healers pose for South Africans’ health, their lack of medical training and the fact that their untested medical concoctions have led to many deaths in the past, were bluntly ignored by the ANC lawmakers. They wanted to reposition traditional healers in new South Africa. Thorough research on the matter was refused, while the untested claims and assumptions were put forward as good reasons to regulate traditional healers and to offer them professional status.1,34,76-79

The promulgation of the Act was initially driven by a one-sided deliberation between various traditional healers’ groups and the DOH of the NP-regime as sole role-players. This resulted in the establishment of an Internal Committee for traditional healers in 1992, followed by the election of a National Steering Committee for traditional healers in 1993. From 1993 onwards, the traditional healers focused their attention on getting formal recognition for their profession from the government (especially the incoming ANC) through various political initiatives. To obtain some guidelines to formulate policies, the National Assembly Portfolio Committee on Health initiated an inquiry with the main focus on three issues.3,58,76-81

These issues were:3,58,76-81:

- the desirability of a statutory council for traditional healers;
- the recognition of medical certificates by traditional healers; and
- the recognition of traditional healers by medical schemes.

Various public hearings on traditional health were held in the country in 1997 under the auspices of the Provincial Standing Committees on Health. The information obtained was drafted into a report by the National Council of Provinces. In 1998, further hearings were conducted by the Portfolio Committee on Health, with a final report in December 1998.3,58
The following recommendations resulted:\textsuperscript{3,58,76-81}:

- legal recognition of traditional healers as a health resource; and
- an Interim Council to be established for the regulation of traditional healing as a profession.

An interim period of three years (up to 2001/2002) was allowed for the Interim Council of Traditional Healers to report back to parliament (this turn-date was extended various times up to 2017). The objective was that a permanent council would be constituted after 2001/2002 if certain conditions had been met.\textsuperscript{41,80,81,100}

It seems as if the general election of 1999 ruled out any input by the Minister of Health in proposed legislation, but various meetings and workshops were still held. In September 2000, the Health Ministry gave the DOH a mandate to implement the Portfolio Committee's recommendation of establishing an Interim Council for Traditional Healers. During 2001 and 2002 the DOH held a series of road shows countrywide for traditional healers, specifically with the aim of engaging them on the matter of regulating their profession. One outcome was the formation of a forum of traditional health practitioners under the guardianship of the DOH. Its task was to consider legislative proposals and the regulation process. In 2007 the Act was promulgated after many delays.\textsuperscript{41,80,81,100}

\textbf{2.8 CONCLUSION}

It is clear that the views expressed in 1994 to support the regulation of traditional healers, which culminated in the promulgation of the Act, were unsubstantiated and politically driven. This occurred in the post-1994 atmosphere of political correctness where positive and constructive objection, reasoning and wisdom were seen as hostility by the current regime. Power, especially political power, can corrupt and intoxicate the noble mind. Prof. Dacher Keltner, a psychologist of the University of California, found after years of research that people under the influence of power react as if they had suffered a traumatic brain injury. Known side effects are impulsiveness, less risk awareness and a serious inability to see life from other people’s point of view or to adapt to others views. Dr David Owen, a British neurologist (and himself an ex-minister in a UK cabinet), stressed that political power, held for years with minimum constraint, can lead to contempt for others, loss of contact with reality, reckless actions and a display of incompetence.\textsuperscript{151}

The foolishness of the promulgation of the Act and the formal statutory recognition of traditional health practitioners as medical practitioners in 2007 are undoubtedly evidence of the presence of the above syndrome among some of the ANC lawmakers. The ANC, as happens with many other
revolution-cum-liberation-groups worldwide when they gain power, has failed democracy with the promulgation of the Act. They put the South African society back in the Middle Ages with an outdated African model like traditional healing because of beliefs of the ex-liberation leaders that they should meet the needs and preferences of the masses to satisfy (liberate) them further in the new South Africa. The Act and its traditional health practitioners, with all their supernatural doings and unscientific inclinations, result from this thinking. They are pre-modern spiritual phenomena with ambiguous statuses, stretching back thousands of years to Apollo’s oracles and wizards.\textsuperscript{1,5,6,7,35,50,72,152}

Calling the ANC regime and its leaders to look for the faulty and controversial promulgation of the Act would be appropriate in a political-historical overview. However, one must remember that the process was put into action in 1990 by the NP regime itself and its DOH. It was the NP that gave the go-ahead for the later legislation on traditional healing under the ANC when they started to rule “officially” from 1994. It is important to note from the above historical overview that although it was the ANC regime that drove the Act to reality after it came into power in 1994, the NP regime already succumbed to the pressure of the ANC to start the process of recognizing the traditional healers as healthcare practitioners in 1990. This means that the Afrikaners via their De Klerk regime themselves approved the first steps to recognize traditional healing, sangomas and the Act in the South African healthcare sector.\textsuperscript{3,58,76-81}

The ANC regime itself has been reluctant to implement the Act fully since its promulgation in 2007 because of its various possible negative implications on South African healthcare, seeing that in 2017 (a decade after its proclamation) it is still only partly implemented. They have sidestepped full enactment over the years, resulting in hostile actions by the traditional healers against the government. Today South African traditional healers still lack comprehensive training facilities, a skilled overseeing teaching-management, education and training curricula, etc., to make it effective.

Notwithstanding this temporary halt, the resolutions of the Act and the right of practice of traditional health practitioners hold many direct and indirect risk and dangers for the South African healthcare sector as well as the general public.

The post-1994 political dispensation has distorted the role of the South African traditional healers and their activities as true role-players in the country’s healthcare sector. The post-1994 government is steering the future healthcare of South Africa based on political opportunism, propaganda, emotional subjectivity and anti-Western healthcare models. The foundation of the Act and the recognition of traditional healers as healthcare professionals are based on
unsubstantiated claims, assumptions and statements, offered shamelessly as truths by official sources. 3,7,8
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DESCRIPTION OF INFORMATION TRANSFERRED FROM CHAPTER 2 TO CHAPTER 3

It is clear that the ANC’s implementation of outdated cultural traditions, customs and habits, like traditional healthcare and the traditional healer, after 1994 is caused by their primary intention to erase as much as possible of the Afrikaner rule and apartheid in period 1912 to 1994 and the unquestioning compensation of the supporters and voters. This single intention led to the recognition of healthcare customs and traditions not based on sound reasoning, but untested and controversial cultural claims, specifically the untested need of the general population for traditional healing.

Strong opposition from some sectors of the formal healthcare society due to the dangers of traditional healers to South Africans health, their lack of medical training and the fact that their untested medical concoctions had led to many deaths in the past, were bluntly ignored by the ANC lawmakers in their desire to re-establish traditional healers in the new South Africa. Thorough research on the matter was refused, while the untested allegations and assumptions were put forward as good reasons to regulate traditional healers and to offer them professional status.

The promulgation of the Act was initially driven by a one-sided deliberation between various traditional healers’ groups and the DOH of the NP regime and later the ANC as sole decision-makers. It is clear that the views and thinking presented in 1994 to support the regulation of traditional healers, culminating in the promulgation of the Act, were unsubstantiated and outright politically driven.

The foolishness of the promulgation of the Act and the formal statutory recognition of traditional health practitioners as medical practitioners in 2007 put South African societies back in the Middle-Ages with an outdated African healthcare model. The various resolutions of the Act and traditional health practitioners’ right to practice hold many direct and indirect risks for the South African healthcare sector and the general public.

The Act has not been fully enacted. Today South African traditional healing still lacks comprehensive training facilities, a skilled overseeing teaching management, education and training curricula, etc., to make it effective.

It is clear from Chapter 2, which reflected on the political-historical development of South African traditional healing, that the traditional healer has never played any role of significance in healthcare and has never been anchored in any substantiated healthcare science. Their history
is founded in the supernatural and is now driven by political opportunism and not as a confirmed healthcare need of the broad population. It is of great importance to understand the legal implications of the Act and the statutory position of the traditional health practitioner with regard to training, skills and scope of practice. The possible future implications for the healthcare sector and the general public in terms of the various statutory resolutions of the Act should also be examined.

This legal context of the Act is evaluated, described and discussed in Chapter 3, titled: Resolutions, implementations and implications of the Traditional Health Practitioners Act (22 of 2007) and the traditional health practitioners on the South African healthcare sector.
CHAPTER 3


3.1 INTRODUCTION

The promulgation of the Act brought new statutory status to the South African traditional healers as recognized health professionals under the professional title of traditional health practitioners. This kind of professional recognition in healthcare is traditionally only awarded after a profession’s formal education in the form of established study programmes and training and its places and facilities of learning have been confirmed; and their diagnosis and treatment model and their scope of practices are identified and fully in place. Guarantees of the future continuation of traditional healing as a viable and sustainable medical entity have also been offered. There should also be a clear indication of a need for the new profession. A statutory mandate was only granted to the South African medical doctors after the South African and international public and the other kinds of healthcare professionals all had a precise understanding of the definition of medical doctor or practitioner and what they will do, their training, skills and abilities. Nearly 50 years ago, the same happened to the South African psychologists. In the psychologists’ case, the psychology fraternity offered constructive evidence, stretching over more than 50 years of sound established professional courses, teaching and instruction by qualified mentors at various South African universities. It was also guaranteed that the identity and entity of the professional psychologist has been established for many years, that the public and healthcare sector understand the definition and was familiar with the actions, training, skills and abilities.1-3

Traditional healers failed to offer an established identity similar to that of the medical doctor or the psychologist. With the support of the lawmakers, they justified the promulgation of the Act with various prominent arguments, like the claim that there are 200 000 and more practicing traditional healers in South Africa, that the ratio of traditional healers versus medical doctors is 7:1 and that more than 80 per cent of the population regularly consult traditional healers. They also claimed that the fees of traditional healers are lower than those of medical practitioners, that traditional healers are the sole owners, manufacturers and sellers of traditional medicines and that these sales amount to an average of R2.7 billion or more annually. Lawmakers involved in the promulgation of the Act failed to confirm these claims. The lawmakers also failed to verify the existence of an education culture and foundation for the South African traditional healers.1-3
South African literature on traditional healing fails to offer any information and guidelines on the resolutions and future implementations and implications of the Act, as well as on the kind and the quality of the training that the traditional healers receive and their abilities to diagnose and treat without risk to the lives of patients.1-3

The prominent question at this stage is whether the Act is applicable to the traditional health practitioners in general as a healthcare law and if the traditional healers’ levels of education and training meet the minimum requirements prescribed for health professionals in the healthcare sector, etc. No formally established education and training infrastructure has ever been developed for the South African traditional healing profession. Up to 2007, there was no governmental support in this regard. A formal education and training system is still in its infancy. There is, however, an informal training system that developed over many years, but the absence of an advanced and statutorily recognized education and training system can make the immediate changeover from traditional healing as an unregulated endeavour to a healthcare profession, together with the acceptance of traditional healers as part of the healthcare establishments, very difficult.1-3

This chapter examines the legal standing of traditional healing as reflected by the resolutions of the Act.

3.2 OVERVIEW OF THE STATUTORY DEVELOPMENT OF THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007)

The presence of traditional healers in greater South Africa goes far back in folklore, which claims that the first official traditional healer was appointed by uShaka kaSenzangakhona (Shaka Zulu), King of the Zulus, when he allowed Nobhiyana Madondo to become his official sangoma (see Addendum B7).4,5 Gumede4 regards this event as a unique Zulu Royal Charter to practise as a diviner. Also, the early official recognition of traditional healers in greater South Africa goes back to their licensing in the Natal Colony and the Union of South Africa between 1895 and 1981. Under White rule, the early licensing of traditional healers in Natal to allow an individual to practice for gain limited the person to the Zulu people. Licensing was only applicable to a specific group of healers, referred to as healing doctors, Zulu medicine men (Izinyanga Zokwelapha, which include midwives, the Umbelethisi) and the herbalists (Izinyanga Zamakhambi). The other healer groups like the wizards, witches, diviners, sky herds or heaven-doctors, rainmakers, etc., were not licensed and were prohibited from practicing for any gain.4
Gumede states that the practice rights of these early groups of licensed traditional healers were included in several proclamations and Acts of Parliament. The KwaZulu Act (6 of 1981) even determined that the provisions of other existing Health Acts should not be constructed as derogating the KwaZulu Act and its registered traditional healers. This means such Acts as the Homeopaths, Naturopaths, Osteopaths and Herbalists Act (52 of 1974), the Medical, Dental and Supplementary Health Services Professions Act (56 of 1974) and the Nursing Act (50 of 1978) were restricted so that they did not limit the rights awarded to traditional healers by the KwaZulu Act (6 of 1981).

These early pro-traditional healers proclamations and Acts include:

- Proclamation No 7 of 1895: Statutes 1845–1899;
- Act No 21 of 1988, Section 33: Statutes 1845–1899;
- Act No 3 of 1957: Statutes 1957;

### 3.2.1 The planning with respect to traditional healthcare for South Africa before 1994

Literature alleges that the main driving force behind the reconsideration of the occupation of the traditional leader from the 1990s onwards was to a certain extent the correction of early discriminative decisions, policies and politics of the South African White regimes related to African cultural beliefs, customs and habits, like traditional healing. The Western healthcare fraternity was also a role-player in this process of limitation. 4,6-9,11

As reflected in Chapter 2, a process of deliberation between various traditional healer groups and the DOH as the main role-players started in the early 1990s, initially under the NP. This was followed by various cooperative actions between the government and the traditional healers, especially after 1994 under the ANC with its “African liberation”-inclination. 6-9,12-15

The outcome was a final report in December 1998 that recommended recognition of traditional healers as a health resource; the establishment of an Interim Council for the regulation of traditional healing as a profession; and the formulation of legalization on the matter. 12-15 An interim period of three years (up to 2001/2002) was proposed for the establishment of the Interim Council of Traditional Healers (ICTH) to report back to Parliament. The objective was the founding of a permanent council to aid legalization of traditional healing after 2001/2002 if certain conditions had been met as prescribed by the lawmaking process. 14-17
The official process around the constructive development of the Council and a concept act on traditional healthcare was stalled by the general election of 1999 and other political events, but notwithstanding these delays, various initiatives by the Health Ministry and the DOH steered the establishment of an Interim Council for Traditional Healers. One main outcome was the decision to compile a proposed bill on the regulation of traditional healers in South Africa. This Bill (No 20) was proclaimed in 2003. 14-17

3.2.1.1 Traditional Health Practitioners Bill of 2003 (No 20)

The pre-1994 lobbying by activists and propagandists to regulate traditional healers and to offer them statutory status was fruitful and led to the proclamation of the Traditional Health Practitioners Bill (2003), introduced in the National Assembly as a Section 76 Bill and published in Government Gazette No 24751 of 14 April 2003.14,15

The Traditional Health Bill of 2003 clearly stated the objective of devising regulation for traditional healers. This is reflected in the Memorandum of 2003 to the Bill (2003). The traditional healers and the DOH as main role-players since 1994 drove this goal and it was ultimately incorporated into the Act.11,13-15

The Bill was a first for traditional healers in South Africa, seeing that it includes all the provinces. It therefore goes much further than the KwaZulu Act (6 of 1981). It had constitutional implications in that it focused on the regulation of a specific South African profession (traditional healers) that had previously been unregulated. This regulation was subject to the government’s interpretation of Section 22 of the Constitution, which they believed stipulates that “all citizens have the right to choose their trade, occupation or profession freely and that the practise of a trade, occupation or profession may be regulated by law.” The DOH, through its legal advising-unit, was content that the Bill was not repugnant to the provisions of the Constitution.14,15,18

At the time of proclamation, the DOH and the law advisors of the South African state were also of the opinion that the Bill should be dealt with in accordance with Section 76 of the Constitution, since it fell within a functional area listed in Schedule 4 to the Constitution, namely Health Services.14,15,18

It was decided that the start-up costs for the incoming Council would be borne by the state. With the passing of time, the Council should achieve a greater degree of financial independence as more and more traditional health practitioners pay registration fees.14,15
The Bill was based on other South African health acts, like those that regulate the Health Professions (56 of 1974) and the allied health professions (63 of 1982).19,20

The Bill’s intention was to provide a regulatory framework to ensure the efficacy, safety and quality of traditional healthcare services; to provide for management and control over registration, training and conduct of traditional health practitioners, students and specified categories of traditional healthcare workers.13,21

The Bill incorporated comprehensive descriptions, definitions and rules in an effort to make effective its implementation (if it became an active Act). It offered precise guidelines on how to establish a council and how to manage the traditional healers in terms of profession registration and rules, offences, and fees to pay. It offered a basic foundation on which traditional healers could develop their trade as a profession. However, some of the Bill’s definitions are vague. Especially controversial are the regulations that give the traditional healers certain practice rights and privileges on the same level as the existing regulated professions of the Health Professional Council of South Africa (HPCSA). The Bill also makes them full members of the health establishment. Specifically, their competence to practise as a healthcare professional in terms of their present training and educational levels is still a point of criticism by the accredited healthcare professionals.11,17

The Traditional Health Practitioners Bill of 2003 was modelled on first-world health legislation applicable to and meant for the start-up of a well-established and well-organized profession, one with existing excellent management styles, learning programmes, a training model, and one that already has some kind of official recognition. Traditional healers did not meet these prerequisites in 2003.

3.2.1.2 Traditional Health Practitioners Act (35 of 2004)

The Bill, when promulgated, was to be called the Traditional Health Practitioners Act, 2003, and would have come into operation on a date to be determined by the President by proclamation in the Government Gazette.14,15

The above Bill was not proclaimed as an Act in 2003 as intended, but only in 2004. It was signed into law on 7 February 2005.13,14,21

Act 35 of 2004, signed into law on 7 February 2005, was based on the Bill of 2003, with a few new inscriptions to make the Act’s contents more clear and precise.14,15,21
This Act was put on the shelf for a short time after the Constitutional Court ruled, after intervention by Doctors for Life (DFL), that the Act be returned to Parliament, as it was improperly processed by the National Council of Provinces (NCOP). The Act was further opposed by the DFL as they argued that a medical practice that is not based on the allopathic system is potentially harmful to the public and can only lead to a waste of their money.\textsuperscript{13,22-25}

\subsection*{3.2.1.3 Traditional Health Practitioners Act (22 of 2007)}

After the government re-traced their steps and held public meetings in all provinces in 2007, the Traditional Health Practitioners Bill (20 of 2007) was approved and the Act was signed into law in 2008. The Act was precisely the same in content as Act (35 of 2004).\textsuperscript{11,21,11/10,21/19}

The primary intention of the Act is to regulate traditional healers and to establish an Interim Traditional Health Practitioners Council to start-up the legislation to regulate traditional healing.\textsuperscript{11,26}

It took ten years of parliamentary struggle from 2003 and 45 years of informal agitation from 1969 to reach the inauguration of the Interim Council in 2013.

The reason why the establishment of the Interim Council was delayed from 2003 to 2013 is unclear. It is problematic to attribute it to the modern Western medical sector of the country, as post-1994 politicians try to do, seeing that the Medical Association of South Africa (MASA) offered written guidelines for cooperation between modern and traditional healers as early as 1995. It rather seems as if the in-fights among the 100 or more traditional healer organizations and the many different types of traditional healers, as well as a lack of governmental support to guide and advise them on the process, played a negative role.\textsuperscript{13,27}

Research suggests that events inside the ANC government also played a role, for instance the expulsion of Mbeki as president of the Republic of South Africa. Mbeki, who signed the Act into law on 7 January 2008, was recalled by the ANC in 2009, leading to the resignation of the Mbeki cabinet. Thereafter, an acting Minister of Health was appointed under the then acting President Motlanthe. The ANC elective conference of 2009 was followed by national elections and the appointment of a new Minister of Health by the new president, President Zuma.\textsuperscript{13}

The new government did not regard the activating of the Interim Council for Traditional Health Practitioners as a priority and it was not high on the priority list of the ten-point plan of the DOH. This led to frustration among traditional healers, which resulted in a march to the Union Buildings in Pretoria in 2011. In a petition the traditional healers raised various points of dissatisfaction.
They alleged that they were treated badly by the Minister of Health and that there was lack of official action to activate the Interim Council. It was only in December 2011 that the National DOH took action and opened nominations for seats on the interim council. Health spokesperson Joe Maila informed the public and traditional healers in the media in October 2012 that the DOH aimed to have the Council up and running by the end of 2012. The Council was eventually inaugurated on 12 February 2013, while the formal establishment of the Council took place on 1 May 2014 by President Jacob Zuma in terms of Section 52 of the Act. A period of three years (up to 2016/2017) was prescribed for the Council to become operative and to report back to the Minister of Health.13,23,25,28

It is clear that the Act is still, in 2017, a decade after its promulgation, not functioning fully and that it is beset with many shortcomings and inexplicit definitions and descriptions. Although some of these shortcomings have in the meantime been corrected with amendments to the Act with the promulgation of Regulations No 1052 in 2015, many more corrections are needed to make it work effectively. If one considers the development history of the Act, is seems that much more time may well elapse before it becomes functional.29,30

3.3 STRUCTURES AND RESOLUTIONS OF TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007)

An effective and well-structured professional body is a pre-requisite for reaching the aims of the registration of traditional healers and the establishment of professional training for traditional healers (see Addendum B8). The Act was the primary body to activate these aims and was promulgated in 2007. This Act’s central role-players in this endeavour are two entities, the Council for Traditional Health Practitioners (CTHP) and its chief executive, the Registrar.11

3.3.1 Main aims of the Act

3.3.1.1 Council for Traditional Health Practitioners (CTHP)

The CTHP has various aims and objectives that cover a broad spectrum of traditional health interests. The training of traditional healers was the main goal of the CTHP. This mandate of the CTHP is fully reflected in various sections of the Act [5(a) to 5(b), 8(2), 9(a) to 9(g), 10(1) to 10(6), 11(1) to 11(3), 12(1) to 12(7), 13(1) to 13(2), 14(1) to 14(5) and 15 to 17].11 These various sections and resolutions are discussed further in the different subdivisions of this chapter.
3.3.1.2 Registrar’s Office

The Registrar’s office is the administrative pivot. This makes the aims and objectives of the Council a reality, especially the future registration of traditional health practitioners, student practitioners and specialist practitioners. The functions of the Registrar are fully described in various sections of the Act [18(1) to 18(2), 19(1) to 19(2), 20(1) to 20(3), 21(1) to 21(6), 22(1) to 22(2), 23(1) to 23(4), 24(1) to 24(4), 25, 26(1) to 26(4), 27(1) to 27(2), 28(a) to 28(c)]. These sections and regulations are discussed in the different subdivisions of this chapter.

3.3.2 Various definitions and descriptions of the Act

3.3.2.1 Section 1 of the Act

Various definitions and descriptions included in Section 1 of the Act make provision for a new statutorily recognized training system, specifically with reference to the traditional practitioner, student practitioner and specialist practitioner. The definition traditional philosophy offers a guideline for the training and education of the traditional healer in the near future.

Section 1 of the Act defines a learning system as part of the definition traditional health practice. The definition describes the performance of a function, activity, process or service based on the traditional philosophy. It includes the utilization of traditional medicine and traditional practice.

The definition traditional medicine in Section 1 describes the specific way in which a traditional health diagnosis is made and is delivered and how patients are treated. This is meant to start on completion of the prescribed training of the traditional healer. Traditional medicine also refers to an object or substance used in traditional health practice.

The traditional healers to be trained in terms of above definitions of Section 1 include the traditional health practitioner in the categories diviner, herbalist, traditional surgeon and traditional birth attendant.

The type of service that the traditional healer should deliver during or after training and the establishment to which he or she must deliver this service after training, are reflected in the following two definitions in Section 3, namely:

- Health establishment refers to any public or private institution, facility, agency building, place or part thereof, whether the organization intends to make profit or not, that is operated or designed to provide health services.
- **Health services** include in-patient or out-patient treatment, diagnostic or therapeutic interventions, nursing and rehabilitative, palliative, convalescent and preventative health services.

The adjective *traditional* is omitted from the above two definitions of the Act. The two other definitions (*traditional medicine* and *traditional health practice*) that do include the word *traditional*, create the impression of a model where traditional healers work in a *parallel* and *separate* healthcare system from the allopathic. This creates a situation where the traditional health practitioners are on one side of a divide and other regulated health professions are on the other side. The traditional health practitioner’s practice is, in terms of this classification, seemingly limited to only *traditional activities* as part of his service and in his place of health delivery. The omission of the prefix *traditional* indicates something else (and indeed contradicts the previous sentence’s intentions), namely awarding full healthcare practitioner status to the traditional healer within the same health system as that of a medical doctor and therefore on the same level. It reaffirms the government’s movement towards granting traditional healers full status as health practitioners and merging (and forcing) traditional healers into the official health sector. This intention brings a shift in the planning and management of the training of traditional healers.\(^6\)\(^,\)\(^9\),\(^11\),\(^12\),\(^16\),\(^17\),\(^31\)-\(^34\)

*The above mentioned inclusion of traditional healers in the circle of established healthcare professions is not really new. The KwaZulu Act (6 of 1981) positioned traditional healers in this manner. The KwaZulu Act (6 of 1981) indeed safeguarded all the traditional healers’ exclusive practice rights and privileges from intervention and interference by the allied and allopathic practitioners in KwaZulu].\(^4\),\(^35\)

### 3.3.2.2 Section 47(1) of the Act

Section 47(1) is very specific about future accredited training institutions, education authorities and traditional tutors. There is also a general reference to fees to pay for training, a register of students and the duration of programmes. The section furthermore establishes minimum requirements for the curricula, the minimum standard of education, examinations, a minimum age, standards for the general education of students who want to enrol and other educational guidelines. These prescriptions are only tentative and without specific time durations, etc., up to 2016, seeing that formal, accredited training is absent. The Traditional Health Practitioners Regulations of 2015 (No 1052) was an amendment to the Act. This Regulation was promulgated in March 2016 and these regulations make Section 47(1)(e) stipulations more focused and the Act more executable. Still, it lacks more descriptive information.\(^11\),\(^30\)
It is clear that Sections 47(1)(b) to 47(1)(e) will be the primary driving force behind the planning and management of the training of traditional health practitioners, although the Act does not say this explicitly. These Sections\textsuperscript{11}, together with the incorporated proposed amendments of the Traditional Health Practitioners Regulations of 2015 (No 1052)\textsuperscript{30}, read as follows:

(a) (i) The registration by the Council of students in any prescribed category of traditional health practice undergoing education or training at any accredited training institution or educational authority or with any master, the fees payable in respect of such registration and the removal by the Council from the register in question of the names of such students. Fees to be paid are foreseen to be R 100.00 for the first year and then R 50.00 per year for subsequent years (Regulations No 1052, 2015: Table of Fees).

(ii) The minimum standards of education and training required of students as a condition precedent to registration. No one may be registered as a student practitioner unless he or she has attained an ABET (Adult Basic Education and Training) Level 1 educational level or equivalent (School Grade 1-3) and has in his or her possession letter of admission indicating the training or course to be done from the tutor or institution registered and accredited by the Council to provide or offer the training or the course (Regulations No 1052, 2015: Regulation 5).

(iii) The duration of the educational programme to be followed by students at an educational or training institution or with a master will be (Regulations No 1052, 2015: Regulations 6):

(1) The Divination student must attend or undergo training for a minimum period of 12 months in which period the student practitioner must learn at least diagnosis, preparation of herbs and traditional consultation;

(2) The student herbalist must undergo training for a minimum period of 12 months in which period the student must learn to identify and prepare herbs, sustainable collection of herbs and dispense herbs and consultation;

(3) The student traditional birth attendant must undergo training for a minimum period of 12 months during which the practitioner must learn issues of conception, pregnancy, delivery of a baby and pre- and post-natal care;
(4) The student traditional surgeon (circumcision) must undergo training for at least five years during which the practitioner must observe in three initiation schools and do supervised practise for two years.

(iv) The minimum requirements of the curricula and the minimum standards of education or examinations which must be maintained at every educational or training institution or by every master offering training in traditional health practice, to secure registration and recognition of the qualifications obtained under this Act;

(b) (i) The minimum age and standards of general education required of a candidate for examination for a certificate, entitling the holder thereof to registration in terms of this Act, are as follows (Regulations No 1052, 2015: Regulations 7):

1. The student for Divination and Herbalism must be at least 18 years old, and Traditional Surgeon and Traditional Birth Attendant must be at least 25 years old, to qualify for registration for a certificate entitling the holder thereof to registration in terms of the Act;

2. The student practitioner should:

   (i) have attained the Level 1 ABET or equivalent;

   (ii) complete courses of study and the training required for examinations at institutions at which, or persons with whom educational courses or training may be undertaken and any other requirements relating to such study or training;

   (iii) register the Council of persons undertaking educational courses or undergoing training and pay the fees payable in respect of such registration. The Council must register the persons undergoing training on FORM THPA3 on payment of the fee of R500 (Regulations No 1052, 2015: Regulation 8/Table of Fees). The following categories of traditional health practice must undergo education or training at any training institution or educational authority or with any traditional healer (Regulations No 1052, 2015: Regulation 3):

   (a) Divination;

   (b) Herbalism;

   (c) Traditional birth attendant’s practice;
(d) Traditional surgeon (circumcision) practice.

(v) The fees payable by candidates for examinations;

(vi) The appointment and remuneration of examiners for examinations;

(vii) Any matter incidental to examinations or the issue of certificates by the Council;

(viii) The nature and duration of the practical training to be completed by persons before they may be registered;

(ix) The nature and duration of the training to be completed by a person who has obtained a qualification as a traditional health practitioner, but who is not yet registered as such, before he or she may be registered as such;

(d) The conditions under which a registered person may practise as a traditional health practitioner or practise in any category of traditional health practice. Regarding the exemption of the pre-requisite of training an applicant who, on promulgation of these Regulations, is a Diviner, Herbalist, Traditional Birth Attendant or Traditional Surgeon may be registered as such by the Registrar on the basis of the documentary proof he or she may produce to the Registrar, or on basis that the community regarded him or her to be a Diviner, Herbalist, Traditional Birth Attendant or Traditional Surgeon (Regulations No 1052, 2015: Regulation 10).

(e) (i) The registration of students of traditional health practice, including the recording of particulars relating to their training and proof of the fulfilment of the requirements thereof (Regulations No 1052, 2015: Regulation 9):

(1) The registered students must submit or cause to be submitted the log book that details the observations and procedures undergone;

(2) The log book must be signed by the Institution or Tutor as proof of the fulfilment of the requirements for the qualification;

(3) The student must submit the certificate of completion of the training from their Institution or Tutor to the Council.
(ii) The health establishments or other institutions, if any, at which or the persons with whom such training may be undertaken;

(iii) Any other matter incidental to the registration or training of students.

Regulation No 1052 (2015) provides for the formal registration of traditional health practitioners with the Council in terms of Section 21 of the Act. This can be done by applying on FORM THPA1 to the Registrar and paying the fee of R 200.00 (Regulation 2/Table of Fees).

Sections 47(1)(b) to 47(1)(e) of the Act and Regulations No 1052 (2015) create a basis for planning and managing the future training and education of the traditional healer. However, these legal guidelines are incomplete and lack detail on planning and managing the effective training of traditional healers. The Act’s training guidelines and intentions need extensive description.

Regarding the vision of the Act, namely to create a new training model for traditional healers, Section 47(b)(i) refers specifically to “any accredited training institution or educational authority.” This undoubtedly means a formal institution that the Interim Council intends to approve and to accept as one that meets the requirements to offer training. It seems that the focus is here on a General/Further Training and Education (FTE) college or some kind of tertiary institution like a South African university.

3.3.2.3 Offering of future learning at private and public places, for profit or not

The implication of Section 47(b)(i) is that a single traditional healer tutor, or a group of traditional healer tutors, can establish a place of learning, private or public, for profit or non-profit (see also Section 1: Health establishment). This outcome of learning from a single tutor is confirmed by Regulations No 1052 (2015): Regulations 4(1)(c)(ii), 5 and 9. One crucial fact is that all such learning institutions (either run by a single person or a group), must be registered in some way with all the prescribed South African education authorities. The same goes for the programmes they want to offer and the education levels of their staff. Accredited institutions are defined in Section 1. It reads: “accredited institution means an institution, approved by the Council, which certifies that a person or body has the required capacity to perform the functions within the sphere of the National Quality Framework contemplated in the South African Qualifications Authority Act, 1995 (Act No. 58 of 1995).”

The standard of the programmes that the traditional healers have to complete as reflected in Regulation 6 of Regulations No 1052 (2015) is clearly at a very low level. This negative profile is confirmed by the ABET Level 1 entrance qualification (School Grade 1-3). The dynamic and high-
level training of the South African traditional healer claimed in literature over the years is clearly non-existent. Regulations No 1052 (2015) reflect this matter as well.\textsuperscript{30}

### 3.3.2.4 In-house apprenticeships

Establishing the new training model for traditional healers as foreseen by the Act will be costly and time-consuming. The obstacles are overwhelming. Ways to train the traditional healer other than the above complicated and costly approach are needed. One such a way is in-house apprenticeships.

The lawmakers themselves were clearly unsure about which avenues to follow to instate training immediately. The only options are training at formal institutions (none exist at present), or continuous training with in-house apprenticeships. Section 47 hints at this with frequent references to the “registered traditional tutor” as equivalent of the formal institution in terms of training [See the phrase “or with any accredited tutor”, in the various sections of 47 b(i), b(iii), b(iv)]. This inclusion surely gives the Interim Council a way out of the proposed new training model of traditional healers as intended by the Act. Regulation No 1052 (2015) echoes this intention of training with many references to future training by a traditional healer as a training entity on its own (Regulations 3, 4 and 9).\textsuperscript{11,30}

An in-house apprenticeship, offered by a master (tutor) traditional healer for a certain period, seems the most obvious solution.

An accredited in-house apprenticeship (for a moratorium period) under an accredited master or tutor traditional healer is a safe and inexpensive way out of the various problems that the new training model brings. It is furthermore clear that Regulations No 1052 (2015) makes the accreditation of tutors in terms of its Regulations (Regulations: 8/Form THPA, 1/Form THPA, 3/Tables of Fees) easy. The allowance that the approximately 200 000 unregulated traditional healers can be registered immediately based on their prior learning will free the Council from immediately creating costly training and evaluation/examination facilities. This can give them time (5 to 10 years) to reorganize the present problematic situation with traditional healing training. They will be able to put formal training institution(s) and formal programme(s) in position to accommodate a new calibre of traditional health student, for instance one with a Grade 12 school-leaver’s certificate instead of the ABET Level 1/School Grade 1-3 as minimum entrance qualification for study. There will be time to write and implement a traditional healer’s curriculum, etc.\textsuperscript{17,30,36}
Formulations such as the registration of students “undergoing education or training with a
traditional tutor” amplify this concern in Section 47 in its Subsections (b)(i), (b)(iii) and (b)(iv). The
primary requirement of the Act is that such a tutor must be accredited. Although the adjective
“traditional” is omitted for “traditional tutors” in Sections 47 (b)(i), (b)(ii), (b)(iii) and b(iv), it appears
as part of the traditional tutor definition (Section 1). This definition prescribes that a traditional
tutor must be a person registered in any of the prescribed categories of traditional health practice
and who has been accredited by the Council to teach traditional health practice or any aspect thereof. Section 44(2) qualifies the clause “registered” with the addition “suitably qualified healer.”
Sections 47(b)(i), (b)(ii), (b)(iii) and (b)(iv), however, clearly makes provision that a tutor, not
necessarily a traditional tutor, but any tutor acceptable for the Interim Council, can be appointed.  

Section 44(2) still leaves the possibility that a student may be trained by an unregistered traditional
healer or another type of health practitioner as long as the training takes place under the
supervision of a “suitably” qualified traditional health practitioner.  

The Act clearly tries to fulfil its main aim, namely to establish a high standard of training for
traditional healers. Certain theoretical guidelines, although vaguely described, are put in place by
the Act to reach this aim. However, it is clear that these aims will take five or more years to reach.
Traditional healers lack the planning and management expertise that would make the immediate
implementation of the initial training model possible.

The complete absence of an advanced traditional health science and culture will not be rectified
easily. The true enactment of the Act will move at a sluggish pace for many years to come.

3.4 LEGAL DEFINITIONS AND DESCRIPTIONS OF THE SCOPE OF PRACTICE AND
SERVICES OF THE TRADITIONAL HEALERS IN TERMS OF THE ACT

Certain legal definitions of the Act serve as primary guidelines in describing the scope or range
of the practice and services of the South African traditional healer (see Addendum 9B). These
definitions are discussed below.

3.4.1 The legal definition of traditional philosophy

The single legal definition traditional philosophy encloses a complex of sub-definitions that
includes various legal descriptions, systems, actions and meanings. These sub-definitions are
further explained by various specific legally defined words and phrases in terms of Section 1 of
the Act. Elucidators are prominent, like “indigenous African techniques, principals, theories,
beliefs, opinions and customs, as well as the uses of traditional medicines communicated from
ancestors to descendants or from generation to generation with or without written documentation, whether supported by science or not, and which are generally used in the traditional health practice.”

The legal definition *traditional philosophy* is the foundation and pivot of the Act. It describes in general the new profession *traditional health practitioner*. It only indirectly and in non-specifics delineates the range of the practices and services of this healer of the future and his medicines. The definition confirms the holistic approach of traditional healing. The link with the ancestors, spirits and supernatural inclinations are the points of focus.

The definition *traditional philosophy* falls into two legal sub-definitions, namely *traditional medicine* and *traditional health practice*.

### 3.4.1.1 Various meanings and definitions of traditional medicine

- **The Traditional Health Practitioners Act (22 of 2007) meanings and definitions of traditional medicine:**

  This Act defines *traditional medicine* as an object or substance used in the *traditional health practice* for the diagnosis, treatment or prevention of a physical or mental illness or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings. The law specifies that this may not include any dependence-producing or dangerous substance or drug.

- **World Health Organization (WHO) meanings and definitions for traditional medicine:**

  The WHO proposes a global and an African definition for traditional medicine.

  The *global definition* describes traditional medicine as the intention to maintain well-being and to treat, diagnose or prevent illness. It refers to diverse health practices, approaches, knowledge and beliefs that can include plant and animal matter, mineral-based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination.

  For *Africa*, specifically, the WHO deviates from its global definition with the added description that traditional medicine is the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or social imbalance. It further stipulates that traditional medicine exists and is maintained exclusively by practical experience and observation, handed down from generation to generation, whether verbally or in writing.
The above WHO definition for Africa is more or less in line with the legal definition contained in the Act. However, it does not include the wording “contact with ancestors.” Although the WHO definition also lacks reference to scientific knowledge, healthcare research and principles as in the definition of the Act, the WHO global version seems to be more scientifically orientated. The discrepancy between the two WHO definitions seems to be an effort on the side of the WHO to accommodate the overall lack of scientific principles and methods in African traditional healthcare, a system that seems still to be reflecting remnants of the old African religions.38,39

The above legal definition of traditional medicine by the Act was not unanimously accepted and sanctioned by all the researchers and role-players involved in South African traditional healthcare.4,38,40-44

Pretorius33 sees traditional medicine as formulas manufactured from various natural substances (animal, mineral and vegetable). She also alludes to the fact that traditional medicines are used for various uses, like placebos, sympathetic magic and medical value.

Holland45, p.15 infers that traditional medicine:

Include[s] medicines for every complaint and aspiration, either dug from fields and forests by individual spiritual specialists to fulfil prescriptions for their own clients, or purchased from herbalists’ shops in the cities of Africa. It is mostly of botanical matter, but it can sometimes include bio-substances like rare lizard fat, snake skin, sunburnt beetles and spiders, lion lard, dried crocodile liver and baboon testicles.

Make use of remedies that may be termed sympathetic magic. For instance, to ensure a good journey, the prescription is made from a root that sends out runners and therefore knows its way. It is founded on the belief that qualities can be transferred to humans, which means that a cream made of the beautifully sleek skin of the python will make the hide of cattle gleam, or that lion’s fat smeared on the arms and legs of a soldier, will make him feared by his enemies. Furthermore, to give a person security, the herbalist may administer a portion of the body of the steadfast tortoise; for swiftness, the sinew of a hare.

Besides the above definitions and descriptions,11,17,37,45 various other definitions of traditional medicine are offered in the literature.51,53 Most of these definitions imply that the healing effect of traditional medicine is negative or unsubstantiated.16,17,37,44,51,53
• Comparing magic medicine, muti and traditional medical mixtures with modern traditional health products

There is a very specific differentiation between traditional medicine and the traditional health products (also known as complementary/supplementary medicines and health products or real traditional medicine) of complementary medicine manufacturers. The Act erroneously defines a grouping called traditional medicine (better known as traditional medical products, which include magic medicine, muti and traditional medical concoctions). Where complementary medical products are manufactured under strict standards of quality control and qualified pharmacists, although independent from the MCC, the traditional medical preparations made by the traditional healers themselves are manufactured with no quality standard or internal professional control.4,40,42,46-50

Mentioned below are some of the other definitions of traditional medical preparations (also often referred to as muti), as reflected in the literature:

• Muti is Black magic, voodoo medicine used by Blacks in South Africa.51
• The most potent muti are the ones that contain human organs, harvested from the victims still alive.51
• Human blood and body parts are essential to the preparation of muti.52
• Muti is a potion from herbs and plants.53
• Muti can consist of human parts that is believed to have supernatural power and that can change or alter the cause of events.53
• Muti is sometimes consumed, but may also be carried about the person who aims to benefit from its powers or secretly smeared onto the body, clothing or included in the food of the target person.52
• Muti does not always involve killing: a living person’s nail clipping may be used in potions targeted at that person.52

The pharmaceutical safety of traditional medical preparations as described in the Act is superficial and misleading. The legal definition of traditional medicine reads “does not include a dependence producing or dangerous substances or drugs.” The Act contains no statutory guarantees or an official MCC certification that the untested and unscientific traditional medical preparations are free from dangerous and prohibited components. The registration of these traditional preparations on the National Pharmaceutical Product Index (NAPPI), the only manual used by the South
African pharmacists and doctors for the issuing of prescriptions, is not allowed. The extent of the negative effect of poisoning as a result of the use of dangerous traditional mixtures is further evidenced by the official establishment of two centres to combat muti-poisoning.\textsuperscript{37,40,46}

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- **The legal definition traditional healthcare practice, including diagnosis, as defined by the Traditional Health Practitioners Act (22 of 2007)**

Various legal definitions are generated by the Act. Its legal definition for traditional health practice refers to the performance of a function, activity, process or service offered specifically by the traditional health practitioner. This description is, as said, primarily based on the legal definition of traditional philosophy, which includes and describes the use of traditional medicine and/or the offering of a traditional health practice.\textsuperscript{11}

Traditional health practice, as described in the sub-regulation of the Act\textsuperscript{11}, has as its goals the following four outcomes:

- Maintain or to restore physical or mental health, or the function of it.
- Diagnose, treat or prevent a physical or a mental illness.
- Rehabilitate a person to enable him/her to resume normal functioning within the family or community.
- Prepare physically or mentally an individual for puberty, adulthood, pregnancy, childbirth and death.

The above four outcomes exclude the professional activities of a person practicing in South Africa any of the professions contemplated in the Pharmacy Act (53 of 1974), the Health Professions Act (56 of 1974), the Nursing Act (50 of 1974), the Allied Health Professions Act (63 of 1982), or
the Dental Technicians Act (19 of 1979), and any other activity not based on traditional philosophy.\textsuperscript{11}

Pretorius\textsuperscript{16, p. 3} describes South African traditional health practice simply as the diagnosis and treatment by traditional healers in general and diviners in particular. Pretorius\textsuperscript{16} postulates further that practices of diagnosis and treatment vary greatly and depending on the healer’s own knowledge, skills and the nature of the patient’s illness. Satisfactory healing involves the recovery from bodily–mental symptoms and the social and psychological re-integration of patients into their communities.

Other researchers offer variations on the official legal description of diagnosis and the follow-up treatment with traditional preparations.\textsuperscript{4,5,4} South African traditional healers see illness as misfortune, a man-made phenomenon as a result of bewitching, evil-doing by another or punishment by an ancestral spirit for bad and sinful behaviour. Opposite hereto, are good health and good fortune seen as rewards for good behaviour. In the traditional healthcare practice, there is no insight or concept of the modern approach of the germ-diagnosis and treatment model. It is not a case of what is causing an illness, but who is causing it. The supernatural therefore drives diagnosis and treatment.\textsuperscript{4,5,4}

- **The misleading prefix “traditional” as used in the legal definition of traditional health practice**

The prefix “traditional” is a prominent legal inscription in the various sections of the Act, seemingly with an aim. It is constantly cited in the first part of the Act, successfully creating the impression that there is a legal separation of the traditional health practice of the South African traditional healer from the modern health practice of the medical doctor (consequently safeguarding the medical doctor from competition by the traditional healer). This tentative dual competence of two types of healers, as created by the unclear definitions in the Act, clearly leaves the door open for two legal interpretations regarding the diagnosis and treatment rights and the scope of practice and services of the traditional healer. This situation is already leading to misinterpretation by the traditional healers and the various official agencies promoting traditional healing and profiling the scope of practice of the traditional healer. These legal contradictions and shortcomings pervade all the sections of the Act. It becomes more prominent later on with the omission of the prefix “traditional” from various legal definitions. This is undoubtedly a masked intention to open the door to the formal healthcare services and to establish a practitioner brotherhood with the statutorily registered healthcare practitioners, specifically the medical practitioner. It is nothing less than a demarcation of the old scope of practice of the traditional healer.\textsuperscript{11}
The legal definition of traditional philosophy, strongly supported by the various sub-definitions of the Act, is poorly formulated and lacks a scientific underpinning. It should therefore be revised comprehensively or recalled, seeing as it is based on a spiritual intention, driven by the supernatural and superstition. It does not contain any scientific medical–legal definition on how to provide a medical diagnosis and medical treatment and does not support a descriptive scope of practice. The other legal terms also require in-depth reconsideration and phasing out, like “indigenous African techniques,” “indigenous African principles,” “indigenous African theories,” “indigenous African ideologies” and “indigenous African opinions.” The above words and phrases must be thoroughly studied, defined and explained to make legal sense of the traditional healer’s present practice system, including his scope of practice.¹¹

The use of a description such as “traditional medicines communicate from ancestors to descendants”,¹¹,⁵⁵ as part of a medico-legal document is unheard of in the modern medical sciences or in what the medical practice regards as true, normal and scientific. One could not regard this phrase as merely symbolic either. The truth is that it is the reality of the thinking and beliefs of the practitioner of traditional healing in the present scope of practice. The same thinking and belief system are applicable to his or her patients. The primary aims and intentions of the Act versus that of the Witchcraft Suppression Act (3 of 1957) confirm this legal short-sightedness and dilemma.¹¹,⁵⁵

It is unacceptable that the phrase “communicate from ancestors to descendants” could be legally inscribed and certified as “true” and “medically scientific” in a health act of South Africa or can be embedded in a healthcare practice.¹¹,⁵⁶-⁶³

It is also unacceptable in these modern times that the training and practice system of a health profession can be based on “no written documentation” of their learning programmes, curricula and the medicines used.²¹ It is also unheard of that legal sanction is given to a health profession of which the “health knowledge and practice, together with its medicines” are free from scientific testing and approval.¹¹ This is the legal sanctioning of an unlimited and unrestricted scope of corrupt practice. It is a recipe for a healthcare disaster.

Neither the Act nor the WHO offers a satisfactory definition of traditional philosophy. This indicates that there is a shortage of knowledge and that an “African Science of Medicine” for traditional healing does not exist.⁴,⁶,⁵⁴ The inclusion of this legal definition in the Act was a desperate and improper effort to put in writing a “non-existing traditional health science” into the South African healthcare legislation.¹¹,¹⁷,³⁷,⁵⁴
It is clear that a South African traditional health practice is non-existing in terms of established healthcare standards, services, ethics, training, diagnoses and treatment. This complete failure is confirmed by the absence of a written and functional practice culture and failure of the Act to formulate a written guideline to activate a future traditional health practice culture for South African traditional healers. It is not possible to speak of a scope of practice for traditional healers.

3.5 THE EDUCATION AND TRAINING LEVELS OF THE SOUTH AFRICAN HEALER IN TERMS OF THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007)

The Act puts certain definitions in place about the education and training levels of the incoming traditional health practitioner (see Addendum 10B). It basically describes how the training of the traditional healer should be directed in the future. The Act and the Traditional Health Practitioners Regulations of 2015 (No 1052) do not describe the contents of traditional healing training, the examination of the learner healer at the end of his training or by whom this should be done.11,30,64,65

3.5.1 The Traditional Health Practitioner Act’s (22 of 2007) description of the education and training levels of traditional health practitioners

Regulations No 1052 (2015)30 prescribes the educational level needed to enrol for training, namely an ABET Level 1-qualification (School Grade 1-3) or an equivalent. Also, Regulations No 1052 (2015)30 prescribes a minimum duration of study for the various sub-types of healers: a 12-month internship for students in divination, herbalist and birth attendants respectively and five years for the traditional surgeon. The Act11 does not describe the structures involved or the training itself, nor does it offer any detailed description of institutions to train new healers.11,30

The intent of health and government authorities to bring the traditional healer, defined as traditional health practitioner, into the established health sector without any formal education and training, training facilities or any established patient responsibility and ethic code through the Act, compounds an already serious situation.11

The current lack of formal training and education for the traditional healers is a direct result of their exclusion, over many years, from a strong education and development system aimed at making practitioners effective in healthcare delivery. This meant that they missed out on support for their early training and development. The situation is different for other health professions. Such empowerment, development and support would have offered the South African traditional healers a start with an excellent system of education and training. This, in turn, would have resulted in an excellent system of diagnosis and treatment, ending in the third and last instance
with an excellent scope of practice. Such a process could have developed them into respected and trusted members of the South African healthcare fraternity years ago.\textsuperscript{64,65}

The traditional healers now stand before an immense challenge. The public and the formal healthcare sector want them to create a formal training and education system as fast as possible. This is something that the established healthcare professions were fortunate to create over many years, mostly with government support. The question is: are the present South African traditional healers really too untrained and uneducated to be proper healers?\textsuperscript{64,65}

The absence of formal registered programmes for traditional healing as part of the National Qualifications Framework (NQF) and the absence of registrations of qualifications with the South African Qualification Authorities (SAQA) do not mean there are no alternative forms of training for traditional healers in South Africa. To the contrary, it is clear from a literature overview that there is an informal traditional health culture of practice and training that is unique to South Africa. In this regard it is important that South African traditional healing is not confused or compared with the training and educational systems, cultures and histories of traditional Chinese medicine, homeopathy, naturopathy or Ayurveda that are also practiced in South Africa. Traditional leaders clearly broke away from these disciplines in the 1970s with the exclusive statutory recognition of the allied health professions in South Africa. This recognition of the allied group further isolated traditional healers from the formal healthcare sector of South Africa and professional healthcare training.

### 3.5.2 Publications and declarations by traditional healing organizations on the current education and training levels of traditional healers

Traditional healer organizations had taken it on themselves to educate and train individuals and groups as traditional healers in an effort to make up for having been side-lined for decades by the established healthcare sector and the formal training sectors. The literature on training produced by these organizations makes it clear that to be registered with one of these many traditional healing organizations, the healer, whether herbalist, sangoma or inyanga, has to have had five years of training as an apprentice healer. The applicant furthermore has to pass an oral and written examination to be awarded the certificate of practice and to be allowed to take the Healer’s Oath of Ethics. Practicing unethically, dabbling in politics and having a bad reputation in the area can cause his expulsion from the organization. These organizations also require that all herbal shops must obtain a municipal license and be registered with the necessary authorities to ensure standards and ethics.\textsuperscript{66,67}
Literature also states that the traditional healers have knowledge of traditions and of healing by means of different traditional health practices. This knowledge is transferred to student healers through their training programmes. Some of their short courses were accredited by the Health and Welfare Services, Education and Training Authority (SETA). It seems that they also offer certified training on ten different traditional health specialist practices.\textsuperscript{66,67}

In an effort to overcome their exclusion from the formal systems and to guarantee the standard of their education and training, the various traditional healers’ organizations also started early on to issue their own certificates of registration and of competence to their students after graduation. With these warrantees they assure every patient that a trained practitioner has completed training of a good standard, has passed assessment successfully and is capable of giving services to the patient in an ethical, efficient, safe and hygienic way.\textsuperscript{68}

Traditional organizations also put rules in place. To qualify and to register as a traditional healer, the candidate has to serve an apprenticeship of between one and five years and the person must be well-known within the community served and among the other traditional healers. Some of these local traditional healers’ organizations have training and work agreements with traditional healers’ organizations of countries in Africa, Asia, Latin America, Europe, and Australia and these organizations seemingly recognize their qualifications. Locally, many of the traditional healers’ organizations also recognize each other’s qualifications.\textsuperscript{69}

From the literature it is also clear that the student-healer sometimes receives in-house training under the guidance of another traditional healer, known as a master- or tutor-healer. This system is more or less in line with the old guild system in Britain where the apprentice or novice trained or articled under a master or tutor for a certain period.\textsuperscript{64,65,70,71}

\subsection*{3.5.3 Researchers’ and writers’ reflections on the educational and training levels of present-day traditional healers}

Literature offers various thorough descriptions regarding the education and training of the traditional healer. These studies also confirm that some traditional healers in South Africa have been through a period of initiation under another traditional healer. Some of them undergo rigorous and complex training and have completed external courses.\textsuperscript{16,17,72-80}

Other researchers\textsuperscript{4} confirm the apprenticeship training, but add that the levels of learning are very elementary: the novice has to do basically only physical and mental exercises. The novice spends a lot of time in the veldt studying nature. She studies herbs as well as under the guidance of her tutor. Dancing the diviner's dance is one of the most important exercises. Her tutor gives her
divining exercises where she has to find hidden objects. She is given many mental exercises, learns meditation, goes into séances, travels to far away lands in dreams and enters into commission with her ancestral spirits. When the tutor is satisfied with the changes, the novice goes through the ceremony for graduation.4

It is further emphasized that learning to be a traditional healer is to be trained formally under another sangoma for anywhere from a number of months to many years and that the training content involves the learning of humility before the ancestors, purification through steaming, washing in the blood of sacrificed animals and the use of muti (self-made traditional medicines) with spiritual significance. During the training period the learner is forbidden to see his or her family, must abstain from sexual contact and often lives under harsh and strict conditions. This intense physical experience of training is part of the cleansing process to prepare the healers for a life of dedication to healing. Their formal education and learning also includes the analysis of dreams.78

Truter81, in reporting on the formal education and training of the different categories of healers, mentions that the training of a sangoma requires training under a qualified diviner for several months. During this learning period, the mentee learns to throw bones and experiences trance-like states where communication with the spirits takes place. On completion of training, he or she undergoes the process of ancestral spirit possession when he or she is called by ancestors to become a healer. There is no fixed period of training; it may take anything from six months to ten years. An inyanga intern spends a few years as an apprentice; the birth attendant’s apprenticeship entails 15 to 20 years of training; while the student umthandazi’s period of training is not described. Qualifying depends on two factors: first, the teacher-sangoma only allows a pupil to qualify once a final fee has been paid, and second, the sangoma retains territorial exclusivity, where the pupil pays allegiance to the teacher.81

Mbiti54 writes also about the education and training of the learner medicine man. Such a person associates with a skilled medicine man for training. This can last up to ten years or even longer. Learning consists of learning the names and nature of herbs, trees, roots, seeds, bones, birds and animal droppings (excreta) and many other things that are used for making medicines. It also consists of learning how to diagnose diseases and troubles of every sort, how to handle the patients, how and what to prescribe as the cure, and in general how to perform one’s duty as a medicine man. All this may be called the “Science of Medicine,” according to Mbiti.54
The healers of the Zulu people, the *inyanga* who specialize in herbal medicine and potions, and the *isangoma* who use divination, mediumship and psychic healing, acquire their knowledge through "long apprenticeships" under a master healer.\(^8^2\)

In Lesotho, most traditional healers are said to have received the calling from their ancestors while asleep (34%). The ancestors reveal to the novice who will train them further on traditional healing. A further 34 per cent acquire their knowledge from their elders, usually as employees of traditional healers. They gain knowledge when they are sent out to fetch herbs or medicinal plants and animals. There is another category (28%) that never goes through any form of training, but claims to have been shown various medicinal plants and animals by their ancestors while asleep.\(^8^3\)

A study involving Bapedi traditional healers (n=34) in Limpopo reflects that most of the males (48%) acquired their healing knowledge from fellow traditional healers, 38 per cent learned it from their parents and 14 per cent from grandparents. Among the females, 62 per cent received training from their parents, 38 per cent from fellow traditional healers and 8 per cent from grandparents.\(^8^4\)

### 3.5.4 Southern African traditional healers' formal scholastic and tertiary education

Another way to gain insight into the healer's level of educational and training is to evaluate the person’s formal scholastic and tertiary education from case studies. Four studies were identified.\(^8^4\)\(^-^8^7\)

A KwaZulu-Natal study with Zulu traditional healers reports that all the healers had attended school in some form, as many as 20 per cent had obtained tertiary qualifications.\(^8^6\) A study with Xhosa traditional healers reflects that 35 per cent attended primary school, 50 per cent secondary school and 3 per cent tertiary institutions.\(^8^7\) The third study, involving 34 Bapedi healers from Limpopo, reports that 76 per cent of the males and 46 per cent of the females had no formal education (average=61%), 19 per cent of the males and 31 per cent of the females attended primary school (average=25%) and 5 per cent males and 23 per cent females secondary school (average=14%).\(^8^4\) The four studies show that very few traditional healers have had tertiary education.

A comprehensive investigation in Lesotho\(^8^3\) used a sample of 91 traditional healers [and 108 users or beneficiaries of traditional medicine]. This fourth study by the African Technology Policy Studies (ATPS)\(^8^3\) found that out of these "traditional doctors," 56 per cent had schooling at a primary level and that 23 per cent had not been to a formal school. Some 14.3 per cent had only attended
traditional schools, meaning that they possess only indigenous knowledge, gained from initiation school and their elders and while tending livestock. Of the traditional healers, only 4.4 per cent attended high school (Grade 8 to Grade 12), while as little as 2.2 per cent obtained some form of tertiary education (NQF 5-level and higher, but not necessarily a tertiary qualification).\textsuperscript{83-88}

In view of modern healthcare standards and requirements, it seems that modern traditional healers in Southern Africa lack medical knowledge and skills. There are no formal programmes, qualifications and learning institutions for the traditional healer. As such, formal quality control of the content, duration or level of their current education and training standards are undefined and impossible to evaluate scientifically. They argue that they learn mostly through the supernatural. One gets training in traditional healing if you have been “called” by the ancestors and spirits, while mental impairment and disarrangement and psychosis also sometimes play a role in this calling.\textsuperscript{64,65}

3.6 THE CURRENT DIAGNOSIS AND TREATMENT MODEL OF SOUTHERN AFRICAN TRADITIONAL HEALERS IN TERMS OF THE ACT (22 OF 2007)

3.6.1 Diagnostic approaches and styles

At present, there is no formal curriculum on traditional health training that directs and instructs the traditional healer on how to make his diagnosis or to perform his treatment (see Addendum 11B). The only official guideline on these matters is linked to the definitions, traditional philosophy and traditional medicine of the Act. These directives are aimed at implementation in future when the Act is fully enacted. At present the only knowledge of the present-day diagnosis and treatment methods and styles of the traditional healer is the definitions, descriptions, declarations, etc., offered by writers, researchers as well as activists and propagandists. This information can be instrumental to reveal the real practice activities of the traditional healer.\textsuperscript{16,17,73,74,76,78,79,90}

Various diagnostic and treatment approaches and practice styles, unique to the traditional healer, are captured in South African literature. These descriptions, although from secondary resources, offer insight into the diagnosis and treatment used in traditional healing and compensate for the lack of formal, written curricula and primary resources on traditional healing.

3.6.2 The traditional healer as a diagnostician

Literature shows that the central role of the traditional healer as diagnostician is to identify through his supernatural powers the reason for unnatural illness and unnatural occurrence in individuals or communities. He must ascertain who (and not what) causes misfortune or illness that can only
be brought on by ancestral spirits or witches. This concept of diagnosis is clearly reflected in the meaning and intention of the definition of traditional philosophy in the Act on which the South African traditional healing is based.4,11,45,54

To be able to perform a diagnosis and offer treatment in line with this traditional philosophy, it is assumed that the traditional healer receives certain supernatural powers to benefit the community through his “heredity-selection.” Accordingly, it is believed that the traditional healer is a sacred servant of the community and in terms of the esoteric knowledge he possesses, he alone can communicate with the spirits on the wills and wishes of the living. Making his diagnosis he relies on magical powers that involve rituals and ceremonies that include the use of substances (muti) made from herbs and animals (and sometimes human parts), verbal spells that are believed to invoke divine intervention as well as the use of esoteric methods and interpretations.4,45,54

This explanation reveals a misconception among people practising and consulting traditional healing concerning the meaning of the notions diagnosis and treatment as understood by modern medicine. This misconception is clearly illustrated by the definition of the “African science of medicine,” which falsely portrays the pre-modern and supernatural training of the traditional healer as based on modern medical principles. The same misconception is reflected by their definition and understanding of the concept “protective medicine” in which healers exclusively use muti for protection against misfortune and illness, while modern medicine regards “protective medicine” as inoculation using safe and effectively tested medicine to prevent an illness like poliomyelitis.54

A further confirmation of this misconception of modern medicine (and the medical diagnosis and treatment procedures that go with it), is the remark by Mbiti54, p. 156 that “medicine in the African society has a wider meaning as in modern society.” It has also been verified that the medical concoctions and muti of the traditional healer do not have the healing qualities of the medicines certified by the Medical Control Council (MCC) medicines. These traditional “medicines” do not intend to heal bio-medically, but is only an expansion of the supernatural diagnosis and treatment of the traditional healer.4,45,54-14

From the ranks of the traditional healers also comes the acknowledgement that they do not have any modern medical diagnosis and treatment at their disposal. For example, being consulted about a new illness a healer might react as follows91, p. par. Healers Herbalists: “On occasion a healer will be confronted with a new and strange disease. In these situations the herbalist will seek assistance from the spiritual world.”
3.6.3 The education and training model of traditional healing guiding diagnosis and treatment

It is clear that the education and training of the South African traditional healer occur in an informal environment of no formal education, controlled standards, learning programmes, established institutions or hospitals. There is no indication of any academic culture equivalent to that of a medical doctor. The traditional healer’s skills, competence and abilities are not in any way regarded as being the same as that of a modern health practitioner. No evidence of a medical culture being embedded in an earlier established medical foundation that still exists today was found. Furthermore, no evidence of a formal traditional healing fraternity acting as the guardian of traditional healing programmes or the teaching of practice and skills that include diagnosis and treatment, was discovered.65,92,93

The present-day traditional healer is evidently a kind of spiritual healer, lacking an acceptable medical identity. The nearest association to the traditional healer with the medicine model is the psychologist and psychiatrist, specifically regarding some practice similarities. But, due to inadequate training, the traditional healer is not able to make a medical, psychological or psychiatric diagnosis in terms of the codes of the International Statistical Classification of Diseases and Related Health Problems (ICD-10 code), to be at the same level with the psychologist or the psychiatrist. In addition, a similar problem emerges for his medical concoctions to obtain rating from the MCC or the SMASA.37,46,90,94-23

3.6.4 The present-day diagnosis profile of the traditional healer

In view of the mentioned findings regarding the traditional healer as a health practitioner without medical certification or licensing and his lack of formal medical or health education, the kind and level of diagnosis and treatment offered appear suspicious.

Literature offers a broad overview of how traditional healers make their diagnoses and treatments. Some approaches present similarities regarding activities, points of focus, creeds, views on present and future life, as well as utilizing certain diagnostic tools and medicinal concoctions. However, certain approaches differ completely and are even in conflict with others.4,78,79,82,83

The various approaches towards diagnosis are mainly the following:

- The traditional healer generally obtains guidance from an ancestral spirit. These instructions usually come through dreams or when praying. The healer receives direction when, where
Some healers employ charms, incantations and casting of spells to make a diagnosis. The dualistic understanding by traditional African medicine of themes such as body and soul, matter and spirit, and their interaction is perceived as magic (witchcraft). It is also believed that healers are able to implant from a distance a foreign object into a person’s body to inflict sickness. To remove this malignant object, the intervention of a second healer is required. He removes the object from the affected person by making an incision. Another form of magic (witchcraft) is the sympathetic magic in which a model is made of the victim. Actions performed on the model are transferred to the victim in a way similar to the familiar actions on a voodoo doll. Where spirits of deceased relatives trouble the living and cause illnesses, the healer applies remedies like propitiatory sacrifice to put the spirits to rest.\textsuperscript{79}

The act of diagnosis and healing in an African context is considered to be a religious act. The healing process attempts to appeal to God because only God can inflict sickness or provide cure. This intervention is performed through the medium of spirits.\textsuperscript{79,90}

Health and illness are perceived in the same light. Traditional healers are consulted for a wide range of reasons such as physical, psychological, spiritual, moral and social problems. Healers are also consulted to obtain ministrations to prevent illness and misfortune.\textsuperscript{83}

While making a diagnosis, the traditional healer always takes into account the connection between the client/patient and his ancestral spirits. The living and the dead have a duty towards each other. Therefore good health or illness is regarded as a net result of a delicate and intricate balance between a man’s family and his relationship with the ancestral spirits. Good health and good fortune are rich rewards for good behaviour and constant sacrifice to the ancestral spirits, while illness is a punishment for sins of commission and omission.\textsuperscript{4}

It is believed that the healer receives instructions and advice from ancestors in the spiritual world to diagnose and heal illnesses, social disharmony and spiritual difficulties. In order to make a diagnosis healers believe that they are able to access advice and guidance from the ancestors on behalf of their clients (patients). This is achieved through possession by an ancestor, channelling, throwing bones, or by interpreting dreams. It is believed that the spirits have the power to cause affliction and they also connect the healer to the acting spirits. Helping as well as harming spirits are believed to use the human body as a battleground for their own conflicts. With his understanding of traditional philosophy on diagnosis, the traditional healer is able to create harmony between the spirits, which results in the alleviation of the patient's suffering.\textsuperscript{78}
Diagnosis is reached through spiritual means, while the resulting treatment consists of herbal remedies that have supposed healing, symbolic and spiritual abilities. In traditional African medicine, the belief is that nobody becomes sick without sufficient reasons and that illness is derived from spiritual or social imbalances within the person. Natural causes (medical or physical) are regarded as the manipulations of spirits or the gods. Sickness is sometimes said to be attributed to guilt in the person, family or village for a sin or moral infringement. The illness manifested stems from the displeasure of the gods due to an infraction of universal moral law. Given the type of imbalance, appropriate healing presupposes a “proper” diagnosis.\textsuperscript{79}

Pretorius\textsuperscript{16, p. 4} refers to traditional diagnosis as “a system that is both an art and a method of seeking to discover the origins of the disease and determining what it is.” The diagnostic process not only seeks answers to the question of how the disease started (immediate causes), but also who or what caused the disease (efficient cause), and why it has affected this particular person at this point in time (ultimate cause). Diagnosis comprises a combination of information, namely observation, patient self-diagnosis and divination. Observation involves noting physical symptoms, while patient self-diagnosis entails patients reporting their symptoms. If deemed necessary, the impressions of other family members regarding the patient’s illness may also be obtained. Three methods of divination are described and include the casting of divination objects, mediumistic ability (clairvoyance/ telepathy) or dreams and visions.

Mbti\textsuperscript{54} and Essien\textsuperscript{95} also emphasize that the major illnesses and life troubles in the African society are usually diagnosed and explained as religious experiences and clearly not as biological/medical conditions as in modern medicine. Essien\textsuperscript{95} reports specifically that the traditional healer’s diagnosis signifies aiding human spiritual health and adjustment through superstition, magic and religious actions and not by real medicine.

Also, in terms of the concept of diagnosis, it is clear that Gumede\textsuperscript{4} sees traditional diagnosis as an essential part of religion, with the central figure accomplishing this diagnosis the traditional healer as a priest, not as a medical doctor.

It is clear that a medical diagnosis, developed by the regulated health professions such as nursing, the allied and allopathic professions, is completely absent from traditional healing. The traditional healer’s diagnosis (traditional diagnosis) is founded in faith in the supernatural.
3.6.5 The present-day treatment profile of the traditional healer

Treatment is only administered after making a diagnosis and deciding on a treatment plan. Several authors have placed on record descriptions of a wide range of treatments offered by the traditional healer.

About the treatments offered by the traditional healers, Pretorius\textsuperscript{16, pp. 4-7} writes:

Traditional medical practitioners treat all age groups and all kinds of problems, using and administering medicines that are readily available and affordable. Their treatment is comprehensive and has curative, protective and preventive elements. Treatment can be either natural or ritual, or both, depending on the cause of the disease. Treatment includes among others, ritual sacrifice to appease the ancestors; ritual and magical strengthening of people and possessions; steaming; purification (e.g. ritual washing or the use of emetics and purgatives); sniffing of substances; cutting (African mode of injection); wearing charms; and piercing (African acupuncture).

Traditional healers also deal with traditional ailments. These culture-bound syndromes usually do not respond to Western medicine and must be treated by traditional healers (Zulu: ukufa kwabantu). There are five such culture-bound syndromes viz being possessed by (evil) spirits, sorcery, ancestral wrath (esinyanya), neglect of cultural rites or practices (amaseko), and defilement.

Regarding the scope of traditional healers' treatment, Pretorius\textsuperscript{16, p. 4} states that the traditional healer deals with the following categories of conditions:

- Conditions of the respiratory system: e.g. colds and flu; hay fever; pneumonia; asthma; bronchitis; emphysema; tuberculosis.
- Conditions of the gastro-intestinal system: e.g. diarrhoea; dysentery; constipation; heartburn; indigestion; ulcers; haemorrhoids; worms.
- Conditions of the cardiovascular system: e.g. angina; high blood pressure; palpitations.
- Conditions of the central nervous system: e.g. headache; migraine; stroke (traditional treatment is given after discharge from hospital).
- Conditions of the skin and hair: e.g. acne; eczema; boils; insect bites and stings; ringworm; scabies.
- Conditions of the blood: e.g. anaemia; blood cleansing.
• Conditions of the urogenital system: e.g. sexually transmitted diseases; cystitis; menstrual pain; vaginitis.

• Conditions of the eyes: e.g. “pink eye.”

• Conditions of the musculoskeletal system: e.g. arthritis; backache; muscular pain; gout; sprains and strains; rheumatism.

• Other conditions such as cancer; HIV/AIDS (some cultural beliefs maintain that there is no such thing as HIV/AIDS or it is sometimes confused with lugola – a culture-bound syndrome that mimics HIV/AIDS); fever; pain; alcoholism.

Another author also indicates that traditional healers use a wide variety of treatments – from "magic" to biomedical methods such as fasting and dieting, herbal therapies, bathing, massage, and surgical procedures. Migraines, coughs, abscesses, and pleurisy are healed by using the method of "bloodletting" followed by an application of herbal ointment with follow-up herbal drugs. Sometimes animals are also used so that the illness can transfer to the animal. Some healers rub heated herbal ointment across the patient's eyelids to treat headaches, while malaria is treated by both drinking and inhaling the steam of herbal mixtures. Fevers are often treated using a steam bath. Vomiting is induced and emetics are used to treat diseases, e.g. raw beef is soaked in the drink of an alcoholic to induce nausea and vomiting as a cure for alcoholism. The fat of a boa constrictor is used to cure gout and rheumatism. It is also believed to relieve chest pain when rubbed into the skin.

Other forms of treatment are purification rituals. The casting of bones to access the advice of ancestors is an alternative practice to the ritual of exorcism of spirits. In a typical session the sangoma would determine what the affliction is or what the reason for the patient's visit might be. The patient or, diviner throws bones on the floor. This collection of objects may include animal vertebrae, dominoes, dice, coins, shells and stones, each with a specific significance to human life, e.g. a hyena bone signifies a thief and will provide information about stolen objects. The sangoma or the patient throws the bones, but it is believed that the ancestors determine the pattern they form when they land. The sangoma then interprets this metaphor in relation to the patient's treatment: what is required from the patient by the ancestors, and how the disharmony would be resolved. Similarly, sangomas also interpret metaphors present in dreams, either their own or those of their patients.

The spiritually curative medicines prescribed in traditional treatments are called muti. Traditional African medicine makes extensive use of botanical products, but may also include other
formulations that are zoological or mineral in composition. Different types of muti are prepared from approximately 3 000 out of 30 000 possible species of higher plants of Southern Africa.\textsuperscript{78}

Depending on the affliction, a number of purification practices can be administered. These practices include bathing in herbal mixtures; self-induced vomiting to cleanse and tone the system; inhaling the steam of medicinal herbs; the use of snuff to induce sneezing to expulse diseases; enema infusions and decoctions and the application of extracts to small cuts.\textsuperscript{78}

In some cases, treatment with the traditional healers’ muti is obviously meant to be ill-disposed, as Hofstatter\textsuperscript{80, p. 18} reveals:

Gris-gris consist of pouches and horns – and sometimes hooves and vials – containing special powders. They are strung along belts, hung around the fighter’s neck or slung over his shoulder. The garland carries a padlock that must be unlocked when not in battle. ‘Otherwise the gris-gris causes discord. You will start fights with your family. Your car won’t be able to start’.

The hoof is a particularly dangerous weapon. ‘During a fight, it can turn you into a snake or the wind so your enemy can’t see you. It is deadly.’ Gris-gris also salves your conscience. ‘When you kill someone, the ghost of the person will not disturb you – the gris-gris will chase it all away’.

Truter\textsuperscript{81, p. 59} identifies three categories of traditional medicine in treatment:

- Preventive and prophylactic medication: Most of the work of traditional healers involves protecting patients from possible afflictions. This can be achieved in various ways, for example by performing ceremonial acts; using medicine against disequilibrium; wearing totemic objects. For fortification these objects are scattered around and about the kraal to ward off lightning or evil pranks that a witch of some kind endeavours to bring about.

- Treatment for ailments: These are prepared in different forms such as cold and hot infusions, decoctions, powders, poultices and lotions, and a variety of earthy ointments that comprise animal fat, clay and sometimes ash. These formulations are made into different medicine mixtures. These recipes are usually a secret and form part of the knowledge that the healer passes onto his apprentice.

- Medications used to destroy the power in others: These medications target specific individuals. A concoction may be placed in the enemy’s path and it is then believed that when the enemy passes by, he will contract a fatal disease. Scarification, bloodletting and cupping are the commonest surgical procedures
performed by African traditional healers and are occasionally performed in full view of onlookers. The letting of blood is sometimes used as a way of casting out the illness. If the cause of the sickness is perceived to be witchcraft, a number of rituals may be performed in order to cast off the spell. These may include the induction of vomiting, enemas, bloodletting, whistling or elaborate rituals such as animal sacrifices. Rituals play an important role. Many Africans believe that if the ancestors withdraw their protection and gift of good fortune, 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 violation of customs and traditions or non-observance of certain taboos. The rituals performed in traditional medicine aim to restore balance and harmony in terms of the beliefs and values of its culture. These rituals reduce patients’ anxiety and serve to relieve feelings of guilt. A large part of the African traditional healer’s practice is also devoted to counselling individuals.

To Mbiti and Essien the treatment with muti is essentially a religious component of traditional medicine. Treatment rituals are necessary to confirm that life’s troubles in the form of magic, sorcery, witchcraft, broken taboos and the work of spirits have been laid to rest. Essien points out that treatment with “medicine” in terms of the traditional healing involves amulets, charms, herbs, sorcery, etc. Such treatment is not meant to heal an illness bio-medically or physically, but to block out supernatural misfortune and illness caused by spirits or witches. These authors do not refer to any modern, scientific or biomedical treatment at all.

The Act fails to rectify the description of treatment by the traditional health practitioner. The scientific intention of its definition traditional medicine, meaning “an object or substance used in traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness, or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug,” is obviated by the Act’s pre-modern pivot definition of traditional philosophy, connecting directly to the ancestors, spirits and supernatural inclinations.

The diagnosis-treatment-model of the traditional healer is exclusively focused on the supernatural. The adjusted term should more accurately be traditional supernatural treatment. The sound medical diagnosis and treatment model of the medical doctor clearly does not exist in traditional healing.

Research also indicates a lack of understanding of the concepts diagnosis and treatment, not only within traditional healing realm, but also among the composers of the Act and certain portions of the South African research community and the general public.
The Act failed to offer any guideline for a diagnosis and treatment model for the traditional health practitioners.

3.7 THE INSUFFICIENT AND VAGUE FORMULATION OF THE DEFINITION
“TRADITIONAL HEALTH PRACTITIONER” AS INCLUDED IN THE TRADITIONAL
HEALTH PRACTITIONERS ACT (22 OF 2007)

3.7.1 Definition Traditional Health Practitioner

In light of the envisioned professional role and practice rights of the traditional health practitioner in the healthcare establishment, it is of utmost importance to determine a definition for traditional health practitioner (see addendum 12B). It is also pertinent to establish which training and skills and what practice scope is embedded in the definition as described in the Act. An evaluation of the Act’s various definitions describing the traditional healer can elucidate this matter.\(^\text{11}\)

3.7.2 The statutory definition of the traditional health practitioner in terms of the
Traditional Health Practitioners Act (22 of 2007)

The person of the traditional health practitioner is prominent in Section 1 of the Act. This definition only reflects the single descriptive name *traditional health practitioner*, which refers to a person registered in one or more of four categories or sub-types of traditional healers. This description entails an immediate conflict with the definition of the medical practitioner, which does not include sub-categories of medical practitioners in its definition. The definition of the traditional health practitioner is purely an umbrella description and it is superficial and misleading. As the definition appears in the Act, it fails to stipulate who the traditional health practitioner really is. Legally and theoretically, the definition is only applicable when the healer is registered for all four the sub-categories at the same time. It also fails to define the scope of practice, training and the diagnosis and treatment approach of the traditional health practitioner. This incomplete definition compounds the registration problems with respect to the alleged approximately 200 000 traditional healers. This presently unknown identity will surely also neutralize any cooperation within the healthcare sector.\(^\text{11}\)

3.7.3 The statutory definitions of the four sub-groups of traditional health practitioners
in terms of the Traditional Health Practitioners Act (22 of 2007)

There are four sub-groups of traditional healers that can be registered under the umbrella term traditional health practitioner. They are in fact the primarily role-players in the delivery of the
intended traditional health services and not the traditional health practitioner as reflected in the Act.\textsuperscript{11}

Sections 19(1) (c), 20(1) to 20(5), 47(f) (i) of the Act identify the four types as follows\textsuperscript{11}:

- \textit{Diviner}, meaning a person who engages in traditional health practice and who is to be registered as a diviner.
- \textit{Herbalist}, meaning a person who engages in traditional health practice and who is to be registered as an herbalist.
- \textit{Traditional birth attendant}, meaning a person who engages in traditional health practice and who is to be registered as a traditional birth attendant.
- \textit{Traditional surgeon}, meaning a person to be registered as a traditional surgeon.

The Act fails to describe the practice scopes, training and methods of diagnosis and treatment of the four categories in the descriptive wording of the four definitions. The description merely tries to associate the diviner, herbalist and traditional birth attendant with the definition traditional health practitioner with the wording “engage in traditional health practice” as reflected in Sections 19(1) (c), 20 (1) and 20 (5).\textsuperscript{11} (This wording is absent from the description of the traditional surgeon. The Traditional Health Practitioners Regulations 2015\textsuperscript{30} adds the following phrase to the description of the traditional surgeon: “as a circumcision practice and to be involved in the initiation schools”).

3.7.4 Other official definitions of the traditional health practitioner in terms of the Traditional Health Practitioners Act (22 of 2007)

Other names allowed in terms of Section 49(1) (e) of the Act in the place of the umbrella name traditional health practitioner seems to be traditional healer and traditional health doctor.\textsuperscript{11} These two official descriptions seem to be of limited value at the moment and only complicate the situation, seeing that they are synonyms for the term traditional health practitioner.

3.7.5 Other common, but non-statutory names used for traditional healers

Literature shows various other names for traditional healers in terms of abilities and tribal uses that are not mentioned in the Act. Some of these names are synonyms for existing names, while some describe unique types of healers.\textsuperscript{11,12,14,16,54,74,78,81,83,96,97}
These names are *ngaka chitja* (herbalist), *ngaka ea litaola* (diviner), *ngakana-ka-hetla* (learner), *Mathuela*, *Moapostola* and *Pentecostal faith healers*. Other general names for the *diviner* are *sangoma* and *diagnostician*, while certain tribes identify the diviner with names like *izangoma* (Zulu), *amagqirha* (Xhosa), *ngaka* (Northern Sotho), *selaoli* (Southern Sotho), *n’ango* and *mungome* (Venda or Tsonga). The *herbalist* is also generally named *inyanga*. In the Zulu culture they are known as *inyango*, while the Xhosas call them *ixhwele* and the Swahilis call them *mganga*. There are Christian practitioners also, called *faith healers* or prophets (known as *umthandazi* in Nguni and *umprofiti* in Sotho). The traditional *birth attendants* are also known as traditional *midwives* or *ababelithisi*, while the traditional *surgeon* is known as *ingcibi*.

### 3.7.6 Gumede’s various doctors of traditional healing

The above-mentioned list of names goes further. The well-known South African traditional health expert, Gumede⁴, identifies many other types of traditional healers (whom he calls specific “doctors in traditional healing”). The Act fails to specify the different categories. According to Gumede⁴, each healer’s group has its own function, with some dovetailing and overlapping.

Gumede⁴, pp. 51-52,77-80,85,92,99,107-109 identifies 20 types of traditional healers, each with a unique name:

- Destructive and evil practitioners
- Abathakathi wizards
- Witches
- Diagnosticians or Diviners
- Izangoma, with types:
  - *Zamathamba* (Bone throwers)
  - *Zehlombe* (Hand clappers)
  - *Zezabhulo* (Stick diviners)
  - *Zegithupla* (Thumb diviners)
  - *Izanusi* (The smellers)
- *Abalozi* (Ventriloquists)
- Amandiki
• Amandawu
• Therapists
• Medicine-men (*Izinyanga zokwelapha* and *Izingedla*)
• Herbalists (*Izinyanga zamakhambi* or *zemithi*)
• Midwives (*Umbelethisi*)
• Specialists
• Sky herds (*izinyanga zezulu*)
• Rainmakers (*izinyanga zemvula*)
• Military doctors (*izinyanga zempi*)
• Disease specialists (*inyangas*) with types:
  • Chief special physicians
  • Heart specialists
  • Kidney specialists
  • Chest specialists

### 3.7.7 Mbiti’s “medicine man” and his other traditional healer types

Mbiti\(^54\) offers further insight into traditional healer types. His book *Introduction to African Religion* does not make reference to the three sub-types of traditional healers of herbalist, birth attendant and traditional surgeon as the Act\(^11\) does, nor does he refer to the term traditional health practitioner. He refers incognito to the Act’s herbalist as a *medicine man*, while he clearly, in addition to the *medicine man*, identifies the *diviner, medium, seer, ritual elder, religion leader, rainmaker* and *priest*. To a great extent his definitions of the different healers/religious practitioners are, like the definitions of the Act, also non-informative and contradictory, only contributing further confusion about the term traditional health practitioner. On the other hand, his definitions offer some useful descriptions of scopes of practice, treatment approaches and diagnoses.\(^54\)

Mbiti’s\(^54,\text{pp.151,155-6}\) definition of *medicine men* says the following of this person’s scope of practice, diagnosis and treatment approach:

They carry out the work of healing the sick and putting things right when they go wrong. Their knowledge and skills have been acquired and passed down through the
centuries; they are the ones who come to the rescue of the individuals in matters of health and general welfare. Major illnesses and troubles are usually regarded, treated and explained as religious experiences, while minor complaints like stomach upsets, headaches, cuts and skin ulcers, are normally treated with traditional medicines.

In persistent and serious complaints, the medicine man has to find out the religious causes of such illness or complaint which is usually said to be magic, sorcery, witchcraft, broken taboos or the work of spirits.

The medicine man prescribes a cure which may include herbs, religious rituals and the observance of certain prohibitions or directions. These measures also involve religious steps and observances. Therefore, the medicine man serves as a religious leader, who performs religious rituals in carrying out his work. Some medicine men are also the priests of their areas. They pray for their communities, take the lead in public religious rituals, and in many ways symbolize the wholeness or health of their communities.

They deal in medicine, which means much more than just the medicine which cures the sick. It is believed that their medicine not only cures the sick, but also drives away witches, exorcizes spirits, brings success, detects thieves, protects from danger and harm, removes the curse, and so on.

About the diviners, mediums and seers, Mbiti\textsuperscript{54}, pp. 158-9 writes that these persons often work with the medicine men and they may even perform the duties of a medicine man:

Diviners normally also work as medicine men and they deal with the question of why something has gone wrong. They can tell who may have worked evil magic, practiced sorcery or witchcraft against the sick or the barren, which spirit may be troubling a possessed person, what it wants and what should be done to stop the trouble. They discover the unknown by means of pebbles, numbers, water, animal entrails, reading the palms, throwing dice and many other methods. Sometimes they get in touch with spirits directly or through the help of mediums. Diviners have knowledge of how to use some of the unseen forces of the universe.

Mediums are people who make contact with the spirit world. They are often women and they are attached to medicine-men or diviners. They can contact spirits at will, normally through ritual drumming, dancing and singing until they become possessed without being aware of it. Under possession they may do things that they may not do when their normal selves and they may communicate with the spirit world. Some mediums are possessed by only one particular spirit. They are said to be ‘married’ to it. Others may be possessed by any spirit. During their possession, they speak in a
different voice and some of them may speak languages that they do not otherwise know. The diviner, medicine man or priest who is in charge of the medium, is then able to interpret what the medium is saying. Most of the communication through a medium comes from the spirit world to human beings; people rarely have messages to deliver to the spirit world. The medium tells people where to find lost things, who may have bewitched a sick person, what types of rituals and medicine are necessary to cure people’s troubles, whether an intended journey will be a success or not, which of the living dead may have a request to make and of what kind, and many other things.

Seers are people who are said to have natural power by means of which they ‘see’ certain things not easily known to other people. Sometimes they foresee events before they take place. On the whole, there is no special training for seers. They are often people with foresight and insight into things. It is also possible that some receive revelations through visions and dreams, in addition to being able to use their intuition. Others have the ability to receive information through forces or powers not available to common man. Seers may be either men or women.

3.7.8 Traditional Surgeon

Regarding the sub-category traditional surgeon, the Act\textsuperscript{11} again does not offer a description of its functions and roles, nor do the writers Gumede\textsuperscript{4} and Mbiti\textsuperscript{54} give any clarity.

The only reference to the practice and functions of the traditional surgeon in the literature up to 2017 comes from a group of South African scientists and public health experts. In a less flattering remark about the abilities of the traditional surgeon in the \textit{SAMJ} of August 2014, they call for the banning of unsterile traditional male circumcision practices by traditional surgeons. These practices often cause death among the young men.\textsuperscript{98}

It was only in 2015 that the proposed Traditional Health Practitioners Regulations No 1052 (2015)\textsuperscript{30} officially referred to the traditional surgeon as a circumcision practitioner involved in initiation schools. This addition to the Act is valid from 2016.\textsuperscript{11}

3.7.9 The Traditional Health Practitioners Act’s (22 of 2007) confusing classification of traditional healers

It is clear that the various types and sub-types of traditional healers differ greatly and are sometimes quite distinct (including their methods and techniques, diagnosis and treatments, and their traditional formulations, muti and medical concoctions). The above analyses, evaluation and
discussion show that defining the traditional health practitioner is much more complex than what the Act reflects in its definition.\textsuperscript{4,11,16,17,30,54,75}

Literature also reveals that the South African Ministry of Health itself acknowledges that there is a variety of healers that can confuse classification. They also admit that no groundwork has even been done to establish systematic approaches to the categories and their specialities. The legislation pertaining to traditional healers should make allowances for this. Lawmakers should take into consideration that the various unwritten categories of traditional healers could differ dramatically in functioning and skills from the statutory defined traditional health practitioner and its four sub-types of healers. These differences can even occur from region to region and clan to clan. It is clear that this differentiation should have been made when statutory recognition was bestowed on traditional healers in terms of the Act. Furthermore, the training of these types and sub-types must be characterized by the institutionalization of standardized training and qualifications before any trustworthy definition of the traditional health practitioner would be possible.\textsuperscript{16,99,100}

The name traditional health practitioner, as reflected in the Act, is defined in English. The same language approach was followed with the four categories of healers in the descriptions.\textsuperscript{11} Considering the South African Constitution’s recognition of cultural uniqueness, these five legal definitions in Section 1 of the Act do not meet the Constitution’s requirements of language and individual (cultural and tribal) rights. It also fails to acknowledge that each of the four official categories of traditional healers can be sub-divided into various other sub-types of healers with unique practice approaches, beliefs and customs, perhaps exclusive to a certain tribe or clan, region or group, as described by Gumede\textsuperscript{4}, Mbiti\textsuperscript{54} and Pretorius\textsuperscript{16}.

First, traditional healthcare professionals have failed to provide evidence of their development. South African psychologists provided proof of 50 years of development to get statutory recognition as a health profession. Second, they have failed to thoroughly establish the identity and entity of the traditional health practitioner over years. They have not created an understanding of the definition of the traditional health practitioner with the public and among other statutory recognized practitioners like the medical fraternity acknowledges the medical practitioner.\textsuperscript{64,65,102-105}

It is clear that the present definition of the traditional health practitioner and the definitions of the four sub-categories of traditional healers as described in the Act\textsuperscript{11} are incomplete, vague and misleading. It fails the main aim of the Act, namely to define the profession traditional health practitioner, especially regarding its scope of practice. About an alleged 200 000 (or more) healers are awaiting registration. Describing each of the four sub-types or the many other types that the
literature refers to in terms of the Act will take immense input and time. It will be impossible for the Interim Council to declare the alleged ±200 000 healers of various healing, cultural, training and experience backgrounds fit to be registered within the present classification, especially if this is expected in a short period of time. The Regulations No 1052 (2015), which is an effort to provide clarity on registration pathways for future traditional healers, also failed to solve the problem.

The traditional fraternity and the compilers of the Act failed to offer a single acceptable definition or description of who the traditional health practitioner is. The definition traditional health practitioner is undefined and insufficiently formulated. This inadequate definition jeopardizes the implementation of the Act and the establishment of professional traditional healing in South Africa.

It is also clear that the education and training, practice, diagnosis and treatment styles and approaches of the various traditional healers cannot be embedded in a single identity as the Act tried to do with the definition of the traditional health practitioner. The inclusion of the traditional health practitioner in the country’s formal health establishment and its acceptance by the established medical fraternity as a profession in healthcare are at this stage clearly impossible.

3.8 THE POSSIBLE IMPACT OF THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) AND THE TRADITIONAL HEALTH PRACTITIONERS ON THE EXISTING PROFESSIONAL RIGHTS AND PRIVILEGES OF MEDICAL DOCTORS

3.8.1 The medical doctors’ historical professional powerbase in the South African healthcare sector

The South African healthcare establishment is primarily managed and overseen by medical doctors (see Addendum 13B). This powerbase was established over many years, especially after the early 1930s. World War Two gave doctors the final approval to take this supervisory and sole decision-making role regarding healthcare training and models of other health workers in South Africa. This phenomenon initially led to doctors having a certain jurisdiction to set the pace and to make the rules. This jurisdiction became more comprehensive and extended with time in South Africa to include a collection of unique medical traditions, customs, privileges, habits, healthcare rights and empowerment, as well as exclusive medical training and practice models to become known as the holy grails of the South African medical doctors. The power of these holy grails has become untouchable to anyone outside the medical domain. Since the 1980s, some powers vested in these holy grails have been lost to the allied health professions and to other insiders of the HPCSA brotherhood itself with the recognition of auxiliary health practitioners, like
psychologists, physiotherapists, etc.\textsuperscript{106-110} The recognition of traditional healers in the Act seems to challenge these holy grails of medical doctors. The Act and its traditional health practitioners can create enormous problems for South African medical doctors in future.\textsuperscript{106-111}

### 3.8.2 Possible future impact of the Traditional Health Practitioners Act (22 of 2007) on the South African medical doctors’ holy grails

The traditional health practitioners as an independent group of health practitioners in the formal South African healthcare sector, empowered by the resolutions and implementations of the Act and free from the guardianship of South African medical doctors as applicable to all the professions governed by the Health Professions Act (56 of 1974), is a dynamic development that can trigger immense challenges and bring changes for South African medical doctors.\textsuperscript{11,19-21}

The resolutions and implementation of the Act directly and openly aim to give traditional health practitioners the same statutory status as that of the allopathic health practitioners in the formal healthcare sector – including working in public hospitals as independent health practitioners. Public hospitals used to be the exclusive domain of medical doctors because of their specific and extraordinary training and skills. The traditional health practitioners’ sub-standard training, skills and their strong religious/supernatural inclinations may put medical doctors under new pressure with respect to their holy grails. It seems in this context as if the Act and the traditional health practitioners pose much more danger to the holy grails of medical doctors than the allied health professions did in 1982. This includes their practice rights, privileges and status, as well as their executive and guardian power.\textsuperscript{11}

Two prominent issues can be fore-grounded. First, the pre-modern methodology of traditional healing spells direct and indirect disaster for the official South African health establishment. It directly threatens the regulated medical doctors’ position and status as main healthcare providers and healthcare executives in South Africa. Second, the recognition of traditional healers seems to have other serious consequences. The power of the different professional bodies, the HPCSA in particular, is endangered. South African medical doctors are concerned not only about losing more of its dominant role in the overall South African healthcare sector, but also about losing its internal authority over the other regulated, but subordinated professions within the HPCSA brotherhood. This means a further loss of holy grails and a levelling of professions, both within and outside the HPCSA brotherhood. The South African medical doctors fiercely opposed this situation in the past to keep their holy grails intact.\textsuperscript{112-115}
For South African medical doctors with their established ethics, traditions, training and professional standards, these various newcomers in healthcare are nothing else than modern imposters with the sole intention to take over parts of the medical holy grails, notwithstanding their seemingly sound arguments and pleas that they are skilled “medical doctors” who are able to deliver comprehensive medical diagnoses and treatments.\textsuperscript{112-115}

The above demanding situation requires a choice between adapting and dying on the side of medical doctors. In the past they could deflect all threats as they had political and social favour. In the new South Africa, this support system is weak, even hostile sometimes. Revisiting and evaluating their holy grails have become unavoidable for South African medical doctors.

It is also worthwhile to note in this regard that after the 1990s, medical doctors again lost some ground when the SAMDC, which conferred enormous power on the medical profession, was replaced with the more democratic HPCSA. In the HPSCA the different professional bodies were empowered, shifting some of the power to the auxiliary medical practitioners.\textsuperscript{19}

Another important outcome of the Act is the right of traditional healers (including White traditional healers that are becoming prominent) to prescribe traditional medicinal mixtures and mutis. This outcome, although possibly not intentionally intended by the Act to influence the allopathic doctors maliciously, can restart, as previously indicated, a long time lingering conflict inside the regulated health professions within or outside the HPCSA. [The prohibition of psychologists, pharmacists and nurses to prescribe medicines independently are of particular relevance. It is a problem that has been demanding attention since the 1970s, but it was put aside and neutralized, first by the SAMDC and later by the HPCSA, as part of the dominance of the medical doctors (and to a certain extent the dentists). Losing such exclusiveness on practice rights would mean the direct collapse of the South African medical doctors’ holy grails].\textsuperscript{64,65,102-104,116,117}

The various resolutions of the Act and its future legal and professional implementation can cause widespread disruption and conflict inside the HPCSA itself. It can lead to sudden and unexpected challenges for medical doctors, challenges they have never had to deal with before and that they are not geared to face with effective constructive counter-actions.\textsuperscript{64,65,102-104,116,117}

One example is the future position of psychologists as equal members with the medical doctors and dentists in terms of the resolutions of the Act and not as auxiliary healthcare practitioners. They are also both equal to the untrained traditional health practitioner who is now allowed to prescribe traditional mixtures to treat mental problems. The fact that psychologists, who are in possession of recognized Master’s degrees in psychology – with many psychologists also
obtaining qualifications in pharmacy, anatomy and physiology and doctoral degrees in psychology – are still prohibited from prescribing any medicine, notwithstanding their clear position in terms of the Health Professions Act (56 of 1974), is creating more and more tension. The traditional health practitioners’ right to make and prescribe medicines spells conflict. Also the right of the traditional health practitioners to be called the courtesy title *doctor* (as with all the allied health professions of South Africa), while the psychologists registered in terms of the Health Professions Act (56 of 1974) are not allowed this privilege (only with a doctorate), reflects discrimination towards the psychologists inside the HPCSA. Together the psychologists and the traditional health practitioners can form a future partnership that has the potential to damage the holy grails of South African medical doctors. \(^{64,65,102-104,116,117}\)

It is clear that the Act can activate shifts in professional registrations. Psychologists can for instance move away from the HPCSA and Board of Psychology to registrations as traditional health practitioners with the THPCSA. It is an open question why psychologists would stay in a registration and with a council/board that limits their practice rights and privileges just to benefit the South African medical doctors. Why would they keep to “talking therapy” when they can also practice “pill therapy” and maximize their practice skills and income like the traditional health practitioners intend to do?

If the Interim Council of Traditional Health Practitioners recognizes the dilemma that the Act can create for the regulated health boards inside the HPCSA regarding their limited and discriminating practice rights and privileges, they can use this dilemma as an opportunity to recruit regulated practitioners like psychologists, pharmacists and nurses from the HPCSA and the Pharmaceutical Council of South Africa and the Nursing Council of South Africa as traditional healers. They can strengthen their professional position. Such recruiting can offer them established manpower, leadership and a powerful direction, far away from the restrictions of the present. It can change the face of South African professional healthcare and delivery dramatically.

**3.8.3 Much needed South African governmental reconsideration of the various healthcare Acts and their role in supporting the medical holy grails**

It is of utmost importance that the South African government also revisits the country’s various Health Acts. This includes the South African Pharmacy Act (53 of 1974), the Health Professions Act (56 of 1974) and the Nursing Act (33 of 2005) to see if they are still applicable to the South African scenario and the needs of present-day South African patients. It is also of importance to consider the rigid authority of medical doctors, which exclusively favours the South African medical doctors in the formal healthcare sector. If the government could promulgate and
implement the Act despite the opinions and will of the regulated health professions, especially the dominating medical doctors inside the HPCSA, what would stop the government from revising all Acts on health, pharmacy and the nursing profession to give the regulated practitioners greater practice rights and to reduce the authority of the South African medical doctors?\textsuperscript{19}

Better health service can be offered if the South African government changes the rule that only the medical and dental practitioners may prescribe independently, especially in rural areas. Effective healthcare professionals can then take over this task from traditional health practitioners.\textsuperscript{12,64}

3.8.4 New Generation of Mental Health Problems and Professions

The fact that more than 30 per cent of the total South African population experiences mental health illnesses and that 75 per cent of them will never receive any psychological and psychiatric treatment, while in the public health sector up to 80 per cent of these cases are neglected, has led to a crisis in healthcare. The fact that the modern medical doctors’ ratio to patients is only 0.8 per 1 000 (against the WHO ideal ratio of 1.67 per 1 000), makes the demand for more healthcare providers prominent. It is in this context that the traditional healers are promoted by activists and politicians and are starting to make in-roads into the formal healthcare sector through the Act, even though it is minimal at the moment.\textsuperscript{113,118-120}

3.8.5 The post-1994 South African political prerogative of African culture in healthcare delivery versus modern-day medicine

In South Africa, authority in the medical and healthcare environment is still mostly the prerogative of medical doctors. They often still cling to their “on top” and “on tap” status. This situation is to a certain extent influenced by cases of financial self-interest that make doctors blind to local and international changes in the types of healthcare practitioners available, the training these professionals received and their new power. Many medical doctors are ignorant of the fact that their traditional established training and professional model, which gave them their socio-economic and political-cultural powerbase in the past, is undergoing enormous changes in developed countries. This is a situation that will surely follow in South Africa in a decade or two. Changes in the mind-set of the present-day medical doctor regarding power division, status, exclusive practitioner rights and financial self-enrichment, cannot be delayed or ignored. It must be noted that the present South African government’s less favourable attitude towards an exclusive European/Western context and way of doing things in medical care and management, are indeed changing. Sometimes this is very noticeable, but mostly it goes unnoticed. The South
African government’s political dimensions have broadened as a result of its admission to the Brazil-Russia-India-China-South Africa (BRICS) Alliance, a group with its own, unique approaches to medical training and models, as the People’s Republic of China has already demonstrated. South Africa’s friend, Cuba, has already given us a good lesson on how effective medical training can be different from ours, yet be done on a great scale. Forced changes to the system and models of the South African medical establishment (as already happened with the regulation of the traditional healers) can and may happen surprisingly fast in the near future. It will therefore be wise for the South African medical doctors to be prepared and to act preventively.

It must also be noted that ANC’s thinking on cultural priorities (including traditional healers), as done with the promulgation of the Act, is slowly forcing South African medical doctors into a negative situation. The negative actions aimed at the modern health sector by means of the Act and due to the present government’s dislike for the European/Western health establishment, are strong destructive indicators for the holy grails of medical doctors. 11,19,31,65,102-104,112-115,117,121-130

The Act is far more complicated and powerful than what the South African healthcare administrators, the public and the regulated health professions think. As said, the Act can have far-reaching effects on the future of the healthcare sector and its regulated health professionals in South Africa beyond its recognition of the pre-modern traditional healer and the practices involved. It will undoubtedly challenge the rights and privileges of medical doctors, both directly and indirectly.

South African traditional health practitioners can become a tool to destroy the position of medical doctors in the South African healthcare sector with their masked “African” identity and superficial indigenous cultural distinctiveness and political favour. This negative impact can also destroy the medical holy grails of the modern medical doctors; especially the degree of power and rights of the medical doctors of South Africa. The Act is a confrontational piece of legislation, intended to take on the South African medical doctors and their authority.

3.9 THE EFFECT OF THE NEW PRACTICE RIGHTS OF TRADITIONAL HEALTH PRACTITIONERS AS STIPULATED BY THE ACT (22 OF 2007) ON THE EXISTING PROFESSIONAL RIGHTS AND PRIVILEGES OF MEDICAL DOCTORS

In 2007, a practice directive was issued for the new legal entity traditional health practitioner with the promulgation of the Act (see Addendum 14B). 11 Although the Act describes this new pathway in terms of various definitions, the future practice rights and their impact on healthcare were left undefined and unwritten. To date the negative legal implications and career consequences that
the Act has for the regulated health practitioners have gone unnoticed. The derogation and
degrading of their work domains and rights seem of no concern. The future practice and services
of traditional health practitioners seem to incorporate many new unwritten practice rights and
activities, which are contrary to the Act’s written intentions. The new traditional health
practitioner’s future practice rights are legally comprehensive and hidden. It holds serious
consequences for the practices of the established healthcare professions.

3.9.1 Some of the future practice rights of traditional healers are left undefined and
unwritten by the Traditional Health Practitioners Act (22 of 2007)

The new policy of 2007 to regulate traditional health practitioners with the Act awarded these
practitioners immense legal rights to practice. Some new activities, rights and privileges are
clearly mapped out, others not. Before this Act there was no legal framework according to which
to regulate and register traditional healers in South Africa. Training and education are non-
existent, as well as an ethics code of professional conduct and a professional position as a
practitioner in the established healthcare sector.11

Although already promulgated in 2007, the Act has still only been partially enacted by 2017. Its
contents and intentions are largely unknown to established healthcare practitioners and the
general public.11

This outcome is that established regulated health practitioners do not always understand or have
a correct legal interpretation of the future implications of these new practice rights for the
healthcare establishment. The various definitions and accompanying descriptions have not been
thoroughly analysed and relayed to the other pieces of healthcare legislation that govern the
medicine, pharmacy, nursing and the allied professions. This ignorance can have serious
consequences for the country’s healthcare management and planning.11

3.9.2 Holistic unity versus the body-mind dichotomy

The compilers of the Act attempted to reassure regulated healthcare professions by means of
different stipulations in the Act that state that the traditional healers will not violate their existing
practice rights and privileges when fully enacted. Three legal definitions, namely traditional
philosophy, traditional medicine and traditional health practice are offered as a safeguard, with
the prefix traditional a prominent addition.11
However, viewed on the whole, the Act seems to actually contradict this safeguard. The prominent use of the term *traditional* in the first part of the Act, while this adjective is largely missing in the second part, is an anomaly.\textsuperscript{11}

This contradiction is further aggravated by the misuse of the popular view of traditional health practice as a holistic unity that involves a holistic physical, spiritual and well-being approach to the human and to illness. The Act shows that it underwrites a body-mind dichotomy. There is a clear description of physical illness on the one hand and of *mental illness* on the other in the discussion of the diagnosis and treatment approach. This practice differentiation most strikingly comes to the fore in the legal definition traditional medicine in Section 1 and Section 49(1) (b) of the Act.\textsuperscript{11} Other literature confirms this observation.\textsuperscript{4,16,17}

The traditional healers’ new practice rights are in conflict with their customary holistic sickness approach to diagnosis and to treatment. The holistic inclination sees the supernatural primary as the reason for illness. This used to be the main argument to regulate traditional healers, but traditional healers’ practice rights have now been extended to meet the rights and privileges of regulated healthcare professions that base their approaches on a body-mind dichotomy. This outcome was unopposed, notwithstanding the fact that the qualifier traditional in the three legal definitions is supposed to limit the traditional health practitioner’s rights to traditional procedures only.\textsuperscript{11}

The conjunction “or” instead of “and” to differentiate between physical and mental in the legal definition of traditional medicine of Sections 1 and 49(1) (b), changes the emphasis of the stipulations regarding practice rights. The emphasis is completely different from the universally and traditionally accepted holistic descriptions of traditional healing that do not separate the natural from the spiritual or the physical from the supernatural.\textsuperscript{7,11}

The emphasis in the Act changes the practitioner’s traditional role as diagnostician. Traditionally, he or she was assumed to have received supernatural powers, either by heredity or from their ancestors, to identify reasons for unnatural illness and unfortunate events, and to mediate with the spirits about the wishes of the living.\textsuperscript{4,45,54}

The practice directive of traditional philosophy as legally defined in the Act stands in contrast to the new trend of exclusively physical diagnosis and the use of muti to treat illnesses directly and separately. This is not traditionally associated with the rights, traditions or skills of the South African traditional healer when viewed as a supernatural holistic unity. In contrast to custom,
Section 49(1) (b) very selectively terminates the limitation “not to may and not to can” venture into the sole treatment of physical illness.\textsuperscript{4,37,45,52,54,131}

3.9.3 Delimitation of the holistic unity

Section 49(1) (b) not only nullifies the traditional healer’s holistic practice uniqueness, but also quietly and selectively terminates in total the limitation of the prefix traditional in the legal descriptions of the Act.\textsuperscript{11}

It is important to revisit Section 49(1) (b) to understand how it violates the practice rights and privileges of the regulated health professions.\textsuperscript{11}

The specification physical health or mental health as separate practice entities and as specific new practice rights are prominent. There is not a single reference to traditional in Section 49(1) (b). Indeed, the traditional healer’s infiltration into the modern healthcare sector is not even masked behind the prefix traditional, as was done in the earlier sections of the Act.\textsuperscript{11}

These earlier references successfully take the attention away from the Act’s real intention, namely to declare the new legal entity, traditional health practitioner, a type of medical practitioner or medical doctor and to bring the healer directly into the health services and health establishments of the country as an equal of the medical doctor.\textsuperscript{11}

3.9.4 Masked intentions of the Traditional Health Practitioners Act (22 of 2007)

Two legal definitions, namely health establishment and health services, foreground the masked intention of the Act to empower the traditional health practitioner within the formal healthcare sector.\textsuperscript{11}

The inclusion of the clause health establishment in the Act clearly provides the traditional healer with direct entrance to practice in any public or private institution, facility, agency, building or place or part thereof, that provides health services.\textsuperscript{11}

This inclusion of the clause health service gives the traditional health practitioner the right and privilege to offer health services inside any of the above official health service establishments. This service can indeed include in-patient and out-patient treatment, diagnostic or therapeutic interventions, nursing and rehabilitative, palliative, convalescent and preventive health service.\textsuperscript{11}
The inclusion of the legal definition of the Department of Health in the Act aims to formally bring traditional health into the private and public health services and health establishments of South Africa. This is clearly part of a long-term political plan starting in the 1960s.\textsuperscript{5-9,31,128,129,132-135}

This intention of the ANC government was openly stated by a Deputy Minister of Health, Gwen Ramokgopa, in 2013 when she acknowledged the plan of the government to integrate traditional healers into the healthcare establishment. She confirmed that many primary healthcare facilities and hospitals are already working in collaboration with traditional health practitioners and that they are members of clinic committees, hospital boards, district health committees, and provincial and national advisory structures with government approval.\textsuperscript{34}

Ramokgopa’s remark is in line with other government efforts from the 1990s onwards to dethrone the medical doctor from his central healthcare position by inserting various community healthcare workers, like traditional healers, into the system so that they are “on top” and “on tap.”\textsuperscript{12,31,128,129,132}

3.9.5 New rights and entitlements for the traditional health practitioners

The limitations that are enforced in the first part of the Act by means of the legal definitions traditional medicine, traditional health practice and traditional philosophy are virtually erased by three specific legal definitions health establishment, health service and Department of Health. They are not qualified by the adjective traditional.\textsuperscript{11}

This is amplified by Section 42(2), which opens the door to health services and establishments by providing for claims of payment to traditional health practitioners from medical schemes in terms of the Medical Schemes Act (131 of 1998).\textsuperscript{11,136}

Section 44(2) states that no person other than a traditional health practitioner registered in terms of the Act and holding the necessary qualifications, is eligible for or entitled to hold any appointment to any establishment, institution, body, organization or association, whether public or private, if such appointment involves the performance of any act that only a traditional health practitioner may perform in terms of the Act. This creates an open-door policy with regard to hospitals and other institutions. It also states that nothing in Section 44(2) precludes the training of traditional health practitioners or students under the supervision of a suitably qualified traditional health practitioner, or employment in any hospital or similar institution of any person undergoing training with a view to registration in terms of the Act under the supervision of a suitably qualified traditional health practitioner or other health professional.\textsuperscript{11}
The new status of the traditional health practitioner as a new kind of medical doctor with the omission of the prefix *traditional* in various legal definitions and descriptions in the Act is also reflected in Section 49, which puts in place various rights of practice. Included here are various unwritten practice rights. Section 49 has serious consequences for the regulated health professions and holds enormous risks for public health. It also discriminates against the healthcare professions psychologist, pharmacist and nurse by bestowing various practice rights on the traditional health practitioner that are totally denied to these professions.¹¹

Section 49 is further confirmation that Government will merge the traditional health practitioners – with their comprehensive new written and unwritten rights to practice – with the public health sector as fast as possible and that they will not consider back-tracking on the Act.¹¹,¹³²

### 3.9.6 Is unprofessional conduct equal to professional ethics?

Government’s official sanctioning of the rights of practice of the traditional health practitioner is further extended with the definition of professional conduct. It is implied in the definition of unprofessional conduct, which reads: “any act or omission which is improper or disgraceful or dishonourable or unworthy if the traditional healer performs or do it”, meaning that he is seen by the authorities as a true medical practitioner with certain (and the same) responsibilities for which he is accountable.¹¹ This sanctioning is regardless of the clear lack of medical training and healthcare standards and ethics among traditional health practitioners.

The above legal definition is specifically applicable to the legal definition of traditional health practice in Section 1 of the Act (read together with the three legal definitions *traditional health practitioner, traditional medicine* and *traditional philosophy*) to guide the traditional healer’s ethics in his traditional practice.¹¹

Professional conduct by the traditional healer takes on new meaning given the goal of the DOH to make traditional healing a full public health service as part of all the health services and in all the establishments of South Africa. This potential for misconduct is increased by Section 49’s attempt to make the traditional healer a full member of the established group of regulated health professions and to grant the healer comprehensive rights and privileges of practice as part of the official health services and in establishments.¹¹

Improper conduct is eminent with the alleged ±200 000 traditional healers waiting to be registered in the near future. They will legally be health professionals without any formal or recognized medical training, experience and skills, and a lack of exposure to modern health facilities. They will be free to heal under their new statutory registration. The pre-modern traditional client now
becomes a modern patient within the structure of medical schemes and health establishments. The modern patient is in other words unwillingly transferred to the traditional health practitioner’s pre-modern traditional health services at public and private facilities. This not only strengthens the traditional healer’s new practice rights, but extends them beyond the unwritten rights.

The above imbalanced power and favouring of the traditional health practitioner in the country’s health establishments, is in contrast with the trained homeopathic doctor, who is currently not included in the public health initiatives of the country and whose services and rights of practice are predominantly limited to the private healthcare sector.¹³⁷

The move of traditional health services to a modern, formal in-patient and out-patient hospital setup is very different from the present practice setup, practice rights and scope of services of the traditional healer. In the traditional context an in-patient lives at the traditional healer’s home for the duration of treatment. The out-patient is visited by the traditional healer, and sometimes the healer stays at the patient’s home to give treatment.⁴ It is probable that these pre-modern consultations, rituals and customs of the traditional healers will become part of the established modern healthcare tradition. Gumede⁴ p. 19 refers very honestly to this when he says: “Consultations take place not in the sterile meaningless environment of the hospital, but at the patient’s home in the environment which is not only familiar but where the problem is and where the living dead will hear the incantations to their persons. They smell impepho and see the sacrificial beasts and roar approval as the goat bleats or the bull bellows when slaughtered.”

There are undoubtedly new unwritten practice rights that will be activated for the traditional healer, not only inside the formal healthcare setup, but also outside the formal healthcare setup, since the healer can enforce his practice rights on the modern patient.

The introduction of the practice services of the traditional health practitioner into the modern health practice and sector may possibly see the replacement of the white coat and stethoscope of the medical doctor in operating rooms and surgeries by the traditional health practitioner’s pre-modern attire, consisting of bandoliers, a sangoma hairdo tagged with gall bladders, a head-umyeko of beads, a sangoma-stick, a “doctor’s bag” consisting of horns filled with concoctions, a broom to sprinkle charm medicine, an ox-tail as a diving ward and a skin bangle of a sacrificial beast to assure victory over illness.⁴

The above possibilities not only mean that these healers can put thousands of innocent lives at health establishments in danger because of their lack of medical knowledge and skills, but also that the ethics and rules of the hospital and patient, as well as the rules prescribed for the healer,
can be transgressed. The “good” professional conduct of the traditional health practitioner, as envisaged in Section 1, can change very fast to “acts or omissions which are improper or disgraceful or dishonourable or unworthy for the traditional health practitioner”, when the traditional healers enter the modern health establishments with their controversial health services, habits and customs, together with their new unwritten rights of practice.\textsuperscript{11}

3.9.7 Other exclusive new practice rights and privileges in waiting

Section 49 further benefits the traditional health practitioner regarding his rights of practice, both legally defined and unwritten. It prohibits the regulated health professions from practicing in any of the physical and/or mental health areas of the traditional healer; identified with the misuse of the qualifier traditional. Only medical practitioners and dentists are exempted by Section 49(5).\textsuperscript{11}

The domain of practice bestowed on the traditional healer in terms of above different rulings, especially Section 49, means that the traditional health practitioner, now with the title “doctor,” can apply and prescribe, in terms of the unwritten rights, any form of traditional “medicine” or concoctions to patients, inside or outside health establishments.\textsuperscript{11}

The treatment of HIV/AIDS and cancer is now, in terms of Section 49(g), also in the practice domain of the traditional health practitioners, notwithstanding their lack of training and their bad reputation when it comes to treating these diseases.\textsuperscript{37,83,135}

3.9.8 Misguidance on the practice rights and privileges of traditional healers by the compilers of the Traditional Health Practitioners Act (22 of 2007)

The above outcomes are good examples of how the compilers of the Act misguided the practice rights of the traditional healer with faulty legal definitions that they derived from the different regulated health professions Acts. The legal guidelines and support fail to compensate for the traditional healer’s lack of scientific training, health principles and ethics, as well as his inability to offer trustworthy health practices. Notwithstanding this failure, the traditional healer’s practice is legalized by the Act, resulting not only in a contamination of future legal and written practice rights, but also of the unwritten future practice rights.\textsuperscript{11}

The traditional health practitioner, in his effort to formulate a professional code of conduct and to gain a status as a respected health practitioner, failed, basically because the legal definition traditional philosophy is his main directive and guideline for future practice rights and his scope of practice and services. Diagnosis and treatment centre on the supernatural, including witchcraft. It is not a biomedical science. Mental impairment is also a strong indicator during supernatural
possession to practice as a traditional healer. This negative mental indicator, coupled with future rights of practice, especially the unwritten rights, can have serious legal consequences for the healthcare sector and the personal and general healthcare safety of patients.

The present professional incarceration of the traditional health practitioner, because of risky and dangerous practices services allocated to him by the Act, was anticipated by the eminent and far-sighted academic and psychiatrist/psychologist, Prof Jan Robbertze, when he warned South Africans nearly 40 years ago: “We are busy with a re-evaluation, I want, however, to warn that we do not lose perspective in the process. We are scientists and we must uphold our scientific traditions for the interest of our patients and the community. We cannot depend on hearsay information, anecdotes and pseudo-social and psychological speculations. In this respect we must especially guard that we do not give in to political pressure and throw our hands in the air and say: Let we give the mass for what they ask.”

This is indeed what the ANC did with the Act in the effort to please the masses.

The new unwritten practice rights of the South African traditional health practitioner are hidden and very comprehensive. The impact of these rights can be much more devastating than the written rights professed and described by the legal definition traditional philosophy embedded in the Act. It empowers the traditional health practitioner with many new practice rights that can infringe on the practice domains of the pharmacist, the nurse, the medical doctor, psychiatrist, psychologist, chiropractor, homeopath, phytotherapist, naturopath and osteopath. It also has the potential for serious medical misconduct, even criminal behaviour, by the traditional health practitioner.

3.10 CONCLUSION

Sound legal formulations and definitions of the various types of healers are needed before the Act’s definitions on the traditional health practitioner and its sub-types can be accepted as legal and as applicable to all traditional healers for registration. At the moment the definition traditional health practitioner fails the test of passing as a uniform professional identity acceptable and useful for all the tribes or ethnic communities in South Africa.

Diagnosis and treatment in traditional health are regarded as unique to the traditional healer and as something that justifies his right to be a healthcare professional allowed to work in South Africa’s health establishment and services in terms of the Act. This is certainly not based on any medical or scientific principle, knowledge or certification. A close examination of literature reveals that there is no uniform traditional diagnosis and treatment model. Specific dissimilarities exist
among traditional healers in their approach to diagnosis and treatment. Furthermore, the traditional healer’s diagnosis and treatment are founded in the supernatural and many times on witchcraft, stripped of any biomedical standing. Its written diagnosis and treatment manifest is carte blanche. As such, it endangers private and public health. South African traditional healers as a group have not yet passed the basic development phase of a medical science and a health profession.

The aim of the CTHP to use the final stage of development of the Act as a guideline for their planning and management of the training of traditional healers is too ambitious at present. They are not medical practitioners and are not trained in elementary medical sciences, but they offer harmful healthcare services. The Act’s provision that traditional healers can treat clients with cancer or Aids with their spiritual knowledge and dangerous medical preparations, is nothing else than making manslaughter legitimate and unpunished. There is no form of training based on formal academic or professional health programmes and standards and attended by the learner healer. In addition, there is no evidence that the traditional health mentor (tutor) is formally trained in health sciences or practice. Traditional diagnosis and traditional treatment are exclusively directed by the supernatural and magic. It is possible that the diagnosis and treatment of the traditional healer are inclined towards witchcraft, even evil-doing, including murder.

The goal of a high level of training, especially full-time training at FET colleges, universities, etc. as proposed by the Act is just too ambitious to become a reality at this stage. The lawmakers clearly never thought through the implications of creating this training. Developing a year-long programme (starting with research, design, compilation and writing) can take one to three years, while the registration process with the different education authorities can take another one to three years. In addition, the development and running costs of such an enterprise come into play: special programme designers must be employed to do research on the content of programmes, while the education authorities prescribe further fees for registration of qualifications on the NQF and SAQA. Finally, the institutions need infrastructure: staff, buildings, facilities (like libraries, computers, textbooks, appointment of salaried tutors, etc.). All this must uphold the prescribed standards of the education authorities.36

It is misleading and irresponsible to describe the present position of the traditional health practitioners in the South African healthcare sector in the following elevated terms81, p. 60: “Their role is that of physician, psychiatrist and priest, and people visit a traditional healer for problems ranging from social dilemmas to major medical illnesses. They therefore have a role to play in building the health system in South Africa.” Their scope of practice is undefined and murky. South Africans should be safeguarded against unregulated medical practices.55 With their current poor
state of education and training, substandard diagnosis and treatment model, lacking a scope of 
practice and services and the absence of healthcare ethics, the traditional healers do not deserve 
a place in the respected statutory healthcare establishment of South Africa. Neither does the Act 
deserve a place as a South African healthcare law. The Act puts South Africans back into the pre-
1994 apartheid legislations of wrongdoings. 4,11,26,139

A scientific traditional healthcare model to guide and teach the student of traditional medicine the 
skills of diagnosis and treatment of his clients, is absent in South Africa. At the moment knowledge 
and understanding of diagnosis and treatment of traditional healing are gained through various 
informal ways of learning, mostly verbally and practically, from “traditional healing masters or 
tutors.” In reality this means that the present-day traditional health advices, styles and approaches 
being offered, differ in standards from tutor to tutor. The lack of an established medical diagnosis 
and treatment learning model and a code of ethics regarding practice responsibility and client 
health safety for the South African traditional healers are matters that have to be addressed soon.

The ANC government has taken steps to dethrone the Western, modern-day medical doctor from 
his central healthcare position since 1990 with its “liberation” thinking, planning and behaviour to 
satisfy the irrational and aimless needs and demands of its dissimilar mass of supporters and 
voters. The traditional health practitioners backed Act is part of this down-grading of the medical 
doctor and the healthcare sector. In light of the present official campaign to enact the Act, the 
traditional health practitioner will surely soon be fully active in terms of the new practice rights, 
written as well as unwritten, offering comprehensive practice services. This outcome spells 
disaster for the established healthcare practitioners, healthcare sector and especially the patients 
using public healthcare services. The evaluation of the resolutions, implementation and 
implications reflects clearly that the Act does not fit into South Africa’s modern-day healthcare 
context, nor does the traditional healers fit into the established group of respected healthcare 
professionals.12,31,128,129,132

A recall of the Act seems impossible. The intent to oust everything that is Western, like Western 
healthcare, is stronger than ever. The Act and the traditional healers are excellent political- and 
cultural vehicles to sustain and promote the pre-modern needs, wishes and preferences of the 
masses. The post-1994 spirit of political correctness and subsequent fear to be harassed has 
silenced any criticism on the evils of traditional healing since 2007. The Act is a law of the country 
with clear legal standing. The traditional healers have become a juridical entity in terms of the 
Constitution of South Africa and this entity has human rights that must be respected at all times. 
In terms of the Act, the traditional health practitioner is a health professional, with certain rights 
and privileges to practice that can be enforced. Written or spoken criticism directed at traditional
healers from objective researchers and writers can be seen as harassment and hate speech in terms of the new set of hate speech legislations that have already resulted in controversial convictions when it comes to racial, political and cultural issues. Critics will be very carefully to take aim at the holy grails of traditional healing in future, at least inside the borders of the new South Africa.
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DESCRIPTION OF INFORMATION TRANSFERRED
FROM CHAPTER 3 TO CHAPTER 4

The outcomes of Chapter 3 are good examples of how the compilers of the Act misguided the practice rights of the traditional healer with faulty legal definitions that they derived from the different regulated health professions acts. The legal guidelines and support fail to compensate for the traditional healer’s lack of scientific training, health principles and ethics, as well as his inability to offer trustworthy health practices. Notwithstanding this failure, the traditional healer’s practice is legalized by the Act, resulting not only in a contamination of future legal and written practice rights, but also of the unwritten future practice rights.¹¹

The traditional health practitioner failed in his effort to formulate a professional code of conduct and to gain a status as a respected health practitioner, basically because the legal definition traditional philosophy is his main directive and guideline for future practice rights and his scope of practice and services. Diagnosis and treatment centre on the supernatural, including witchcraft. It is not a biomedical science. Mental impairment is also a strong indicator during supernatural possession to practice as a traditional healer.⁴,⁷ This negative mental indicator, coupled with future rights of practice, especially the unwritten rights, can have serious legal consequences for the healthcare sector and the personal and general healthcare safety of patients.

The new unwritten practice rights of the South African traditional health practitioner are hidden and very comprehensive. The impact of these rights can be much more devastating than the written rights professed and described by the legal definition traditional philosophy embedded in the Act. It empowers the traditional health practitioner with many new practice rights that can infringe on the practice domains of the pharmacist, the nurse, the medical doctor, psychiatrist, psychologist, chiropractor, homeopath, phytotherapist, naturopath and osteopath. It also has the potential for serious medical misconduct, even criminal behaviour, by the traditional health practitioner.

Sound legal formulations and definitions of the various types of healers are needed before the Act’s definitions on the traditional health practitioner and its sub-types can be accepted as legal and as applicable to all traditional healers for registration. At the moment the definition traditional health practitioner fails the test of passing as a uniform professional identity acceptable and useful for all the tribes or ethnic communities in South Africa.

The diagnosis and treatment used in traditional health are regarded as unique to the traditional healer, justifying his being a healthcare professional that is allowed to work in South Africa’s health establishment and services in terms of the Act. This is certainly not based on any medical
or scientific principles, knowledge or certification. A close examination of the literature reveals that there is no uniform traditional diagnosis and treatment model. Specific dissimilarities exist among traditional healers in their approach to diagnosis and treatment. Furthermore, the traditional healer’s diagnosis and treatment are founded in the supernatural and many times on witchcraft, stripped of any biomedical standing. This endangers private and public health. South African traditional healers as a group have not yet passed the basic development phase of a medical science and a health profession.

The aim of the CTHP to use the final stage of development of the Act as a guideline for their planning and management of the training of traditional healers is too ambitious at present. They are not medical practitioners and are not trained in elementary medical sciences, and they sometimes offer harmful healthcare services. The Act’s provisions, guiding traditional healers can treat clients with cancer or Aids with their spiritual knowledge and dangerous medical preparations, amounts to rendering manslaughter legitimate and unpunished. No form of training based on formal academic or professional health programmes and standards and attended by the learner -healer can be found. In addition, there is no evidence that the mentor (tutor) is formally trained in health sciences or practice. Traditional diagnosis and traditional treatment are exclusively directed by the supernatural and magic. It is therefore possible that the diagnosis and treatment of the traditional healer is inclined towards witchcraft, even evil-doing, including murder.

The goal of an immediate high level of training, especially full-time training at FET colleges, universities, etc. as proposed by the Act are just too ambitious to become a reality at this stage. The lawmakers clearly never thought through the implications of creating this training. Developing a year-long programme (starting with research, design, compilation and writing) can take anywhere from one to three years, while the registration process with the different education authorities can take another one to three years. In addition, the development and running costs of such an enterprise come into play: special programme designers must be employed to do research on the content of programmes, while the education authorities prescribe further fees for registration of qualifications on the NQF and SAQA. Finally, the institutions need infrastructure: staff, buildings, facilities (like libraries, computers, textbooks, appointment of salaried tutors, etc.). All this must uphold the prescribed standards of the education authorities.36

With their current poor state of education and training, substandard diagnoses and treatment model, lacking scope of practice and services and the absence of healthcare ethics, the traditional healers do not deserve a place in the respected statutory healthcare establishment of South Africa. Neither does the Act deserve a place as South African healthcare law. The Act puts South Africans back into the pre-1994 apartheid legislation of wrong-doings. 4,11,26,139
Chapter 3 shows that a scientific traditional healthcare model to guide and teach the student of traditional medicine the skills of diagnosis and treatment of his clients, is absent in South Africa. At the moment knowledge and understanding of diagnosis and treatment of traditional healing are obtained from various informal ways of learning, mostly verbally and practically, from so called “traditional healing masters or tutors.” In reality, this means that the present-day traditional health advice, styles and approaches differ in standard from tutor to tutor. The lack of an established medical diagnosis and treatment learning model and a code of ethics regarding practice responsibility and client health safety for the South African traditional healers are matters that should be addressed soon.

Chapter 3 (together with Chapter 2) lays the foundation for the evaluation of this total research project. The main intention of the study is to determine if the Act and the statutory recognition of the traditional healers could edify the South African healthcare establishment based on the information generated by Chapters 2 and 3 by the five articles presented in Chapters 4 to 8.

The first of the five articles is titled: Does the traditional healer have a modern medical identity in South Africa? This article tests the hypothesis of empowerment in terms of the traditional healer’s abilities and skills to be accepted as a medical professional.
CHAPTER 4

DOES THE TRADITIONAL HEALER HAVE A MODERN MEDICAL IDENTITY IN SOUTH AFRICA?

(Article 1)

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ABSTRACT

Research supports the view that the South African traditional healer does not hold a modern medical identity, but developed from the Traditional African Religions and cultural environment as a kind of caregiver. The name healer with a medical connotation arose from early colonists and missionaries who misunderstood the role of a traditional healer in Africa, especially in early South Africa. There is misunderstanding even today about the African meaning of spiritual healing. As such, the traditional healer is a remnant from a previous, pre-modern time of living. Traditional healers were forced to the foreground recently in South Africa by the Act. This act makes the traditional healer an exclusive healthcare practitioner with statutory status under the name traditional health practitioner. Such a healer can practice in the formal healthcare sector, including the public hospitals. The Act gives the healer the right to diagnose, treat and to make and prescribe pre-modern health products to his/her clients. It is clear that the various resolutions and implementations of the Act intend to bring the South African traditional healer into the practice domain of the South African medical doctor. The new South Africa did start changing socially, economically and politically after 1994. Most of them left behind many of the pre-modern beliefs, like the traditional healer and the accompanying supernatural activities and practices. The present-day political and cultural pressure from politicians with outdated thoughts by means of things like the Act, are being met more and more with resistance by the broad population. It is therefore important to research changes in cultural values and styles, economical positions and the medical needs of the country's population to understand if the traditional healer has a true
medical identity in modern South Africa. The Act has failed to include the outdated traditional healer in the modern South African society and formal healthcare sector as a specific medical entity. The foundations of South African society have changed too dramatically to allow space for a pre-modern cult practitioner.

Key Words

Identity, indigenous, oracle, priest, ritual, sorcery, traditional healer
4.1 BACKGROUND

Literature on the South African traditional healer, including the Act and its definitions of traditional medicine, traditional philosophy and traditional practice, include many references to the traditional healer’s *medical identity*. These references intimate that the traditional healer is a kind of medical entity and an essential part of the healthcare of Black South Africans, especially for those in the poorer rural areas.\(^1\,^2\)

This alleged medical identity was clearly one of the main reasons for the promulgation of the Act. The concept of the belief in the supernatural that is specifically built into the Act, is seen as an exclusive part of the traditional healer’s health practice.\(^1\,^2\)

The medical fraternity is very sceptical about the abilities, skills and diagnostic approaches of the traditional healer as a healthcare professional, especially in the medical sector.\(^1\,^2\)

Other research shows that the claim that the traditional healers contribute to healthcare is untrue. The role of the traditional healer in the South African society as a healthcare worker or medical healer seems to be minimal. This includes all practice activities, like herbalism and divinity. In general, approximately 1.4 per cent of the population makes use of traditional healers, and since the 1990s there has been a constant decline in the demand for these services in South Africa.\(^1\,^2\)

The view that the traditional healer has a medical identity seems to be doubtful and needs further evaluation.

4.2 AIMS AND OBJECTIVES

The aim of this study is to determine if the traditional healer has a medical identity in modern South Africa.

4.3 METHOD

The research was done by means of a literature review. This method is aimed at building a viewpoint based on the available evidence as research on the subject developed over time. This approach is often used in modern historical research where there is a paucity of information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for the period 1989 to 2014, articles from 1982 to 2016, books from 1958 to 2013 and government documents covering the period 2007 to 2012. These sources stimulate reflection on the development of the Act and its assumption of the medical identity of the traditional health practitioner in modern South Africa.\(^3\,^4\)
The findings are offered in the narrative form.

4.4 RESULTS

4.4.1 Traditional Healers’ Lack in Medical Education and Training

The education and training of traditional healers in South Africa was and is still done in an informal manner. There are no education standards, formal learning programmes, established institutions, etc. There is no academic culture equal to that of the medical doctor. The traditional healers’ skills, competence and abilities are of a much lower standard than those of the medical doctor in South Africa. It is not possible to be registered in terms of the Health Professions Act (56 of 1974) as a kind of health practitioner with the HPCSA without adequate training. This medical culture is absent among the South African traditional healers. There is no evidence of an educational foundation on which to establish medical training programmes or to learn practical biomedical skills, including diagnosis and treatment in the near future.5-11

4.4.2 Erroneous names “medical” or “health” associated with the traditional healer in South Africa

The assumption that the South African traditional healer is a true medically trained healthcare professional, someone with a unique medical distinctiveness similar to that of the medical doctor, seems to be untrue.9-13

The question is therefore: why is the traditional healer referred to in literature and even in the Act as a kind of medical doctor, traditional health practitioner, medicine man, traditional doctor, etc., if this is not the case? A certain part of the public and some of the authorities seem to share this view of traditional healers. The reason is simply that these names, especially the name “traditional healer” (with the connotation of “medical” or “health”), is an erroneous name, introduced many years ago by the early colonists and missionaries of South Africa and accepted and offered in research as such since then. The South African “traditional healer” as we see and understand the term and the true role, abilities, training and position of the healer, have never been properly researched and defined. The name traditional healer has wrongly been included in the Act to refer to a kind of medical practitioner. This deception was driven and established further by the traditional healing fraternity and their propagandists.9-11,14

An in-depth look into the writings of various independent African writers with deep African roots, like Mbiti,15 Boon,16 Gumede14 and Essien,17 clearly explains this mix-up and the misleading use of the name traditional healer in South Africa as a kind of medical practitioner instead of as a
religious practitioner, like a priest or spiritualist. It is clear from their descriptions that the identity of the traditional healer is solely that of a religious practitioner.

Essien\textsuperscript{17} clearly classifies the traditional healer as a crucial component of traditional (old) African religions. Essien\textsuperscript{17} sees the act of healing by the traditional healer as divine and not medical as the Act tries to profess. Essien\textsuperscript{17} reflects that the traditional healer’s healing acts are aimed at aiding human health by adjusting to superstition, magic and religious actions. The cures offered for diseases and illnesses, or any other kind of human health danger, are purely religious and supernatural treatments. It includes the use of “medicine” that Essien\textsuperscript{17} identifies as amulets, charms, herbs, sorcery, witchcraft and muti. The aim of this “medicine” is specifically to block out or to help avoid misfortune, mishaps and sicknesses or to counteract sorcery and to put a stop to the evil spells of witches. Nowhere does Essien\textsuperscript{17} refer to modern or real scientific medicine, diagnoses and treatment.

Gumede\textsuperscript{14} also sees the traditional healer and the healing process as an integral part of religion. The healer is described as a “gifted man of God” and a parallel to the minister and evangelist. About the traditional healer’s prominent religious role during his home consultations, Gumede\textsuperscript{14}, p.\textsuperscript{144} writes: “He opens proceedings with a prayer. The head of the family is requested to offer a goat – which is at the ready. The goat is killed by cutting the throat so that it bleats. This rings a bell to summon all the clans. All the spirits of the departed ancestors are alerted to remain at attention. The head of the family then sings the praises of the old ancestral spirits or the chiefs departed. The traditional healer is performing his duties as the emissary of Umvelingqangi for he is both healer and priest.”

Gumede\textsuperscript{14} sees the approach of the traditional healer as social, political, economical, moral, religious, recreational and related to a change of environment. A true medicinal approach based on modern medical science for diagnosis and treatment is absent.

Boon\textsuperscript{16} defines the work role of the sangoma in particular and sees the traditional doctor, traditional healer or diviner as the term is used in the Act, as a priest-healer (meaning to heal or restore through spiritual actions) and not a medical healer who are treating patients biomedical. This classification of the traditional healer as a priest, spiritualist, a seer and religious leader and not at all as a medical healer, is supported by the descriptions and definitions of many other researchers.\textsuperscript{18-23}

Mbiti\textsuperscript{15}, whose research and writing played a dominant part in defining the African traditional healer, indeed calls the traditional healer a “medicine man,” but, he adds that this person is active
in a total of eight religious roles in the African society, especially in the role of the priest. Mbiti\textsuperscript{15} writes: “Religion has deep roots in people’s lives. Therefore, to make it function properly in society, there are often men and women who have religious knowledge, and who know how to lead others in religious activities, and who serve as the link between their fellow human beings on the one hand, and God, spirits, and invisible things, on the other. We find many such leaders in all African societies. Their knowledge of religious matters varies considerably. Some of them are professionals, and therefore well trained and skilled. Others only take the lead when the need arises, otherwise living and working like ordinary people. Some are rulers and national leaders, and it is their positions which embody religious beliefs and emotions. In many ways, religious leaders are the embodiment of what is best in a given religion. They embody the presence of God among people, and the faith or beliefs of the people, as well as their moral values. Without them, African Religion would disintegrate into chaos and confusion. The religious leaders are the keepers of religious traditions and religious knowledge. They are wise, intelligent, and talented people, often with outstanding abilities and personalities. They include medicine men, diviners, mediums, seers, priests, ritual elders, rain-makers, and rulers.”

Both Mbiti\textsuperscript{15} and Essien\textsuperscript{17} emphasize that all major diseases, illnesses and life troubles in the African society are usually regarded, treated and explained as religious experiences and not as biological/medical illnesses and diseases as modern medicine would understand it. For Mbiti\textsuperscript{15} and Essien\textsuperscript{17}, contrary to modern medicine's diagnosis and treatment, the muti of the traditional healer is essentially a religious act and a “ritual” needed to assure that life's troubles, in the form of magic, sorcery, witchcraft, broken taboos and the work of spirits, are laid to rest.

Mbiti,\textsuperscript{15} Boon,\textsuperscript{16} and Essien’s\textsuperscript{17} own misunderstanding of the true meaning of words like “medicine,” “medical,” “healer,” and their subsequent wrong use of these names for a religious priest or practitioner, are reflected by Mbiti’s\textsuperscript{15} inappropriate description of the “African science of medicine.” In this description, he portrays the religious, pre-modern and supernatural training of the “medicine man” as based on a real medical foundation, similar to that of the modern medical doctor. The same misconception is also reflected by Mbiti’s\textsuperscript{15} definition and understanding of the concept “protective” or “preventive” medicine, namely the use of muti for protection against misfortune (a term that in modern medicine would means to inoculate with safe, effective and tested medicine to prevent an illness like poliomyelitis).

Mbiti’s\textsuperscript{15,p.156} uncleanness and lack of knowledge about what real modern medicine is, is also revealed by his naïve remark that “medicine in African societies has a wider meaning.” He also tries to divert attention from the fact that “medicine in African societies” does not mean the same and is not connected to modern medicine and modern healthcare whatsoever in his
"For African people, the word medicine has a lot of meaning. It is unfortunate that in the English language it has a limited usage." The truth is that Mbiti’s “medicine” is solely spiritual and his “medicine man” is a spiritual healer.

**4.5 DISCUSSION**

It is clear that traditional healers and the pre-modern medical products that they prepare and use as part of their treatment are far removed from modern biomedicine. They are not health practitioners or medical doctors. However, the name “traditional healer” in reference to the pre-modern African milieu does not have any other meaning in modern society.

The medical meaning ascribed to the term traditional healer was endorsed from 1652 onwards in South Africa by a portion of the public, researchers and later on the lawmakers of the Act. Be that as it may, it is a misconception that has become a deception in our daily life.

It is clear that the role of the traditional healer, specifically as a skilled kind of medical practitioner in present-day South Africa, is minimal. Their rituals, customs, practices and muti can primarily be associated with the supernatural, witchcraft, demons, bad magic, witches and other negative or problematic behaviours, instead of scientific medical actions and healing.

The South African traditional healer is at most a priest or spiritualist: no medical role and identity can be allocated to him.

**4.6 CONCLUSION**

It is clear that the traditional healers’ training, practices and treatments have been erroneously construed as medical over many years, while these practitioners are actually priests or spiritualists. There is a claim that traditional healers play a “distinctive” role as a kind of medical practitioner in the modern South African healthcare sector. However, this role refers to an 11.2 per cent consultation rate in limited rural areas by a very small segment of the poor population. The general use of the traditional healer by the total population is only 1.4 per cent. This 1.4 per cent represents a maximum patient base of only between 75 801 and 607 041 persons. When it comes to consultations on truly “medical” problems, this number of users is even lower.

The maintenance of the medical identity of the traditional healer in South Africa by means of the Act seems to be politically motivated. The post-1994 dispensation has given rise to political leaders and opportunistic politicians with hidden agendas. They abuse the traditional healers by presenting them to the public as a religious and cultural heritage that must be retained, playing
on the emotions of the electorate. This unhealthy political climate is also abused by the traditional healers themselves to advance their own interests by means of the Act and to promote their professional status as a kind of medical healer or practitioner. Traditional healers with all their supernatural doings are pre-modern spiritual phenomena with an ambiguous status.\textsuperscript{31-37}

The South African traditional healers’ assumed exclusive medical identity is non-existent in the modern South African society. The Act is clearly inapplicable and inappropriate in its aim to accommodate and to regulate an outdated kind of pre-modern priest, spiritualist or caregiver as a kind of health or medical professional inside the formal health establishment of the country. This kind of registration belongs exclusively with churches, outside governmental healthcare regulation and relationship.

Emperor Theodosius declared in 400 AD about the evil doings of the oracles and wizards of Apollo that:\textsuperscript{38,p.110} “no mortal man shall have the effrontery to encourage vain hopes by the inspection of entrails, or to attempt to learn the future by the detestable consultation of oracles. The severest penalties await those who disobey.”

It seems as if the Act had tragically pushed back South African medicine nearly 3 000 years to 600 BC and the oracles and wizards of Apollo.
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DESCRIPTION OF INFORMATION TRANSFERRED FROM CHAPTER 4 TO CHAPTER 5

Research shows that the claim that the traditional healers contribute to healthcare is untrue. The role of the traditional healer in the South African society as a healthcare worker or medical healer seems to be minimal. This includes all practice activities, like herbalism and divinity. In general, approximately 1.4 per cent of the population makes use of traditional healers, and since the 1990s there has been a constant decline in the demand for these services in South Africa.

The education and training of traditional healers in South Africa were and are still done in an informal manner. There are no education standards, formal learning programmes, established institutions, etc. There is no academic culture equal to that of the medical doctor. The traditional healers’ skills, competence and abilities are of a much lower standard than those of the medical doctor in South Africa. It is not possible to be registered in terms of the Health Professions Act (56 of 1974) as a kind of health practitioner with the HPCSA without adequate training. This medical culture is absent among the South African traditional healers. There is no evidence of an educational foundation on which to establish medical training programmes or to learn practical biomedical skills, including diagnosis and treatment.

It is clear that traditional healers and the pre-modern medical products they prepare and use as part of their treatment are far removed from modern biomedicine. They are not health practitioners or medical doctors. However, the name “traditional healer” in reference to the pre-modern African milieu does not have any other meaning in modern society.

The assumption that the South African traditional healer is a true medically trained healthcare professional, someone with a unique medical distinctiveness similar to that of the medical doctor, seems to be untrue.

Chapter 4 shows that the role of the traditional healer, specifically as a skilled kind of medical practitioner in present-day South Africa, is minimal. The South African traditional healer is at most a priest or spiritualist: no medical role and identity can be allocated to him.

The maintenance of the medical identity of the traditional healer in South Africa by means of the Act seems to be politically motivated. The post-1994 dispensation has given rise to political leaders and opportunistic politicians with hidden agendas. They abuse the traditional healers by presenting them to the public as a so-called religious and cultural heritage that must be retained, playing on the emotions of the electorate. This unhealthy political climate is also abused by the traditional healers themselves to advance their own interests by means of the Act and to promote
their professional status as a kind of medical healer or practitioner. Traditional healers with all their supernatural preoccupations are pre-modern spiritual phenomena with an ambiguous status.

The South African traditional healers’ assumed exclusive medical identity is non-existent in the modern South African society and it is clear from Chapter 4 that the Act and the traditional health practitioner do not contribute to the official healthcare sector in any way.

The second of the five articles is titled: Is the traditional Health Practitioners Act (22 of 2007) in conflict with the Witchcraft Suppression Act (3 of 1957) in present-day South Africa? This article tests the hypothesis that the Act and the traditional healer contribute to the present-day healthcare sector. The basic test is to see if the Act is in conflict with the Witchcraft Suppression Act (3 of 1957) and whether it is appropriate as a piece of healthcare legislation.
CHAPTER 5

IS THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) IN CONFLICT WITH THE WITCHCRAFT SUPPRESSION ACT (3 OF 1957) IN PRESENT-DAY SOUTH AFRICA?

(Article 2)

Authors: Louw, G. P. & Duvenhage, A.


ABSTRACT

The Traditional Health Practitioners Act (22 of 2007) with its aim to regulate the traditional health fraternity had been driven since the 1960s and became a reality after the advent of the 1994 political dispensation. Although the Act was already promulgated in 2007, it is still not active. Certain definitions of the Act are very controversial, especially the role of the supernatural in healing, which could be associated with witchcraft and criminal behaviour. From the data extracted from various sources it seems as if the Act was promulgated without thorough research on the role that the traditional healer can play in witchcraft activities. The aim of the Witchcraft Suppression Act (3 of 1957) has been ignored. The Witchcraft Suppression Act (3 of 1957) does not discriminate against the Act. Instead, it seems that various stipulations of the Witchcraft Suppression Act (3 of 1957) are transgressed by the traditional healers without legal action being taken against them.

Keywords

Discriminative, law enforcement, partial prosecution, scapegoating, supernatural, traditional philosophy, witch, witchcraft
5.1 BACKGROUND

The South African lawmakers, activists and the traditional healing fraternity ignored the existence of the Witchcraft Suppression Act (3 of 1957) with the promulgation of the Act, which has as its aim to define the statutory status of the traditional health practitioner and traditional healing as a health profession.

This erring seems to have serious implications for the traditional healer’s future ways of making diagnoses, treatment as well as training. The supernatural, witchcraft, wizardry, etc. seem to be part of the traditional healer’s practice activities in terms of the Witchcraft Suppression Act (3 of 1957), which are illegal. It seems also in terms of the Witchcraft Suppression Act’s (3 of 1957) regulations as if some of the definitions included in the Traditional Health Practitioners Act (22 of 2007) are illicit.

The Witchcraft Suppression Act (3 of 1957) elicited much criticism by the traditional healing fraternity. Already enacted in 1957, it went fairly unnoticed until 1994, seemingly because it was enacted by the apartheid regime and fitted well in this previous regime’s legal and governmental thinking and rulings up to the new political dispensation of 1994. Opposition was not possible or allowed. The Constitution of 1996 and the Bill of Rights brought the opportunity to object freely to any supposed human rights violation. After 1996, opposition to the Act from individuals, human right activists, the neo-pagans and the traditional healers, became more prominent. Especially their agitation in terms of Section 5 of the Civil Union Act (17 of 2006), and support by outsiders like the Lawyers for Human Rights (LHR) put them on the foreground.1-5

5.2 AIMS AND OBJECTIVES

The aim is to determine if the Witchcraft Suppression Act (3 of 1957) is discriminative against the traditional healer if the Traditional Health Practitioners Act (22 of 2007) and the traditional healer contravene the regulations of the Witchcraft Suppression Act (3 of 1957).

5.3 METHOD

Research information and other literature on the legal standing of the Witchcraft Suppression Act (3 of 1957) are very limited, except the information published on the websites, journals and other publications by the neo-pagans, traditional healers and some individuals, reflecting their opinions, viewpoints, statements and own findings. This research strongly relied on this information, especially publications and appeals aimed at the South African Law Reform Commission (SALRC) in an effort to get the Act repealed.
In light of above information shortage, the exploratory and descriptive research method was used. It offered the researcher the opportunity to review and to consider new information as the research progressed. The narrative form is used to reflect the findings.6,7

5.4 RESULTS

5.4.1 The Traditional Healer

Of all the role-players that object in some way against the Witchcraft Suppression Act (3 of 1957), the traditional healers seem to be the main role-players. This may be due to the conflict between the Traditional Health Practitioners Act (22 of 2007) and the Witchcraft Suppression Act (3 of 1957) and the possible interactions between these two acts when regulating the traditional healer’s diagnosis, treatment and training.

In the following discussion, the intentions of the Witchcraft Suppression Act (3 of 1957) are compared with that of the Traditional Health Practitioners Act (22 of 2007). The diagnosis, treatment and training practices of the traditional healer as described and condoned by the Traditional Health Practitioners Act (22 of 2007) are evaluated against the rulings of the Witchcraft Suppression Act (3 of 1957) to see if it is legally acceptable.

5.4.2 The 1957 scapegoating of the witch and neo-pagans

In contrast to some individuals and the neo-pagans who want the Witchcraft Suppression Act (3 of 1957) to be repealed in its entirety without any other witchcraft legislation to replace it, the traditional health fraternity is far more radical and wants the Witchcraft Suppression Act (3 of 1957) to be replaced by a new stricter law that strikes a balance between protecting innocent people accused of witchcraft and punishing those found guilty of practising witchcraft.8

This inclination brings conflict between the South African Pagan Council (PCSA/SAPC), which sees witchcraft as a “noble practice” and the THO, which distances itself from wizardry and which argues that witches and witchcraft should be punished with the full severity of the law.8

The hostile and snobbish attitude and dissociation from the “witch” and “witchcraft” (including neo-paganism) by the traditional health fraternity has a long history. It resulted from the very same Witchcraft Suppression Act (3 of 1957) with its specific scapegoating of the witch (“wizard”) as the only criminal entity that commits witchcraft-related crimes, like muthi-, ritual-, religious-, cultural- and other crimes (including murder), and therefore the one who can and must be prosecuted by a court of law. The viewpoint was sensationalized and driven over the years by the
media, opportunistic religious and governmental groups and internalized in the minds of the public, regardless of whether these assumptions were true or false. Through the Witchcraft Suppression Act’s (3 of 1957) rule of law, the “bad witch” was totally isolated as a stand-alone social, health, religious and cultural figure and a criminally orientated practitioner that only intends to harm the innocent.\(^9\)

The 1957 scapegoating declared the traditional healer unofficially as “good” against the “bad” of the “witch,” distracting the attention away from the traditional healer that was often accompanied by its own negative connotations. The differentiation between the other regulated health practitioners as “good” and the “witch” on the other hand as “bad”, was grabbed and promoted by the opportunistic traditional healers; especially after the promulgation of the Traditional Health Practitioners Act (22 of 2007)\(^4,9,10,11\)

### 5.4.3 The possibility of the Witchcraft Suppression Act (3 of 1957) causing discrimination against the Traditional Health Practitioners Act (22 of 2007)

The present legal setup of the traditional healer sanctioned and certified as able by the Traditional Health Practitioners Act (22 of 2007) as a statutory healthcare practitioner, will be evaluated using the rules of the Witchcraft Suppression Act (3 of 1957) to see if there are similarities or contradictions between the two acts. For this it is important to state the main aims of the Witchcraft Suppression Act (3 of 1957), namely:

- To prevent any person or a community to identify a specific person (notwithstanding his position or doing, to justify such an identification) as a “”wizard”” through witch-finding;
- To prevent this identified person (“wizard”) from being harmed (threatened, terrorized, victimized or even murdered) in any way by the “witch-finder” or the community;
- To prevent a person from calling himself a “wizard” by prohibiting such self-naming / declaration as a crime, with the sole aim of safeguarding him against harm by his own wrongdoing, to be identified as a “wizard” by the “witch-finder” and the community [see (a)]. [For full text see Section 1(a) to (f) (i) – (iv)].

Comparing the two acts to determine if the Witchcraft Suppression Act (3 of 1957) has negative effects on the activities of the traditional healer, two sets of data can be used: i) the witchcraft statistics of 1994 to 2004 of the 2006 Report of the South African Parliament; and ii) the six descriptions of witchcraft offences in terms of the Witchcraft Suppression Act (3 of 1957). These six offences are reflected in Table 5.1.
5.4.4 The 2006 Parliament Report

The statistics of the 2006 report of the South African Parliament reflected that by 1994, only 13 persons had been convicted on the accusation of identifying another person as a “wizard” and/or of actions to harm such an identified person as a “wizard.” In 2004, ten years later and with much more strict implementation of the act, these convictions had risen to 345 cases (a rise of 332 or 96.2% in cases) [Officially the SAPS does not keep specific statistics on muti or ritual assaults and murders. This limited an in-depth study on the matter from 1957 to present. It forced the use of a few studies (like the 2006 report of the parliament)].

The 2006 report shows that in 1994, only ten cases of withdrawal occurred, with nil acquittals; in 2004 there were as many as 567 cases of withdrawals and 141 of acquittals. (In the withdrawn cases the rise was 557 or 98.2% and in the acquittal cases the rise was 141 or 100%).

It is also argued that the dramatic rise in the registration of witchcraft-related cases in a period of ten years from only 23 (10 withdrawals, 14 convictions and nil acquittals) in 1994 to 1 053 (567 withdrawals, 345 convictions and 141 acquittals) in 2004 by law enforcement agencies like the South African Police Services (SAPS) and the National Prosecution Authority (NPA), means that the Witchcraft Suppression Act (3 of 1957) is an effective and working piece of legislation. Also, it is argued that these statistics, together with the law enforcement bodies involved, confirm that the Witchcraft Suppression Act (3 of 1957) is in use.

The opinion is that the Witchcraft Suppression Act (3 of 1957) is not intended to do any harm or injustice to the law-abiding citizen, even if the person transgresses some of the regulations of the Act, knowingly and wilfully. The Act is only focused and applied in terms of its main aims: to prosecute only the crime-intended individual who would normally be prosecuted under any of the other criminal codes for serious law-breaking. In terms of the Witchcraft Suppression Act (3 of 1957), the context of the focus is “the person who names, identifies and sniffs out any other person as a wizard and who intends to do or is involved in doing such person harm in one or other way.”

The opinion is also that only certain sub-rules of the prescribed rule 1(a) to 1(f) are really implemented with the aim of prosecuting, meaning that the Witchcraft Suppression Act’s (3 of 1957) regulations are only partially executed. Determining the true impact of this assumed execution of Section 1(a) to 1(f) is very difficult, seeing that governmental agencies do not refer specifically to witchcraft-related crime statistics or other research outcomes. The only guide to review the use of the Witchcraft Suppression Act (3 of 1957) is the writings and appeals of the
neo-pagans, individual objectors and other interest groups that focus their writings on the repealing of the Act, or those who are doing research on the Act’s benefits and shortcomings.\textsuperscript{2,8,11,13,14}

In the evaluation in Table 5.1, the six main offences, as described by Section 1(a) to 1(f) of the Witchcraft Suppression Act (3 of 1957), are compared with the statistics on witchcraft convictions of the 2006 report of the parliament for the period 1994 to 2004.\textsuperscript{2,8,11,13} These outcomes are reflected in Table 5.1:

Table 5.1 reflects that convictions occurred with respect to three of the six types of offences (reflected by Section 1 as infringements of the law). This means that no more than 50 per cent of the prescribed offences have been utilized for prosecution and that the opinion that the Witchcraft Suppression Act (3 of 1957) is indeed only partially implemented is corrected.

The traditional healers can surely not object that the Witchcraft Suppression Act (3 of 1957) is discriminative. It can be concluded that the traditional healer’s practice is undisturbed by the Act.

The outcomes of Table 5.1 are vague and not fully informative about the alleged partial prosecution approach of the law-informing agencies. A more detailed analysis is needed. In this regard it must be noted that the six offences reflected in Section 1 of the Traditional Health Practitioners Act (22 of 2007) are compiled and described with the incorporation of different offence descriptions to obtain the six descriptions. These incorporated descriptions can lead to an over-simplified interpretation of the partial or full executing approach of the Witchcraft Suppression Act (3 of 1957).

5.4.5 The re-written 14 single offences

In an effort to obtain a more precise profile of a specific offence relating to a specific conviction, the above six offence descriptions were separated where the legal meaning diverges. The offences were re-written to reflect specific (single) offences only. With this focused approach, 14 single offences relating to the practice of witchcraft, were identified and described. In Table 5.2 these 14 offences relating to witchcraft are compared with the witchcraft statistics of the 2006 parliament report for the period 1994 to 2004.\textsuperscript{2,4,8,10,11,13}

To put this in perspective, the rules of the Traditional Health Practitioners Act (22 of 2007), and Section 1 (Offences relating to the practice of witchcraft and similar practices) of the Witchcraft Suppression Act (3 of 1957) include under in 14 descriptions for clarity. In terms of Section 1(a) to 1(f), an offence is committed by any person who:\textsuperscript{8,11}
• imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing;
• names or indicates any other person as a wizard;
• in circumstances indicating that he professes any supernatural power, witchcraft, sorcery, enchantment or conjuration;
• in circumstances indicating that he 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;
• employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard;
• professes a knowledge of witchcraft, to bewitch, injure or damage any person or thing;
• advises any person with any pretended means of witchcraft;
• supplies any person with any pretended means of witchcraft;
• on the advice of any witchdoctor, witch-finder or other person 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;
• 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;
• for gain pretends to exercise or use any supernatural power, witchcraft, sorcery, enchantment or conjuration;
• for gain undertakes to tell fortunes;
• for gain 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.

Table 5.2 reveals only three offences with convictions out of the 14 offences, meaning that as much as 78.5 per cent of the regulations were apparently not used in law enforcement. This is in line with the opinion obtained in Table 5.1, which shows that the Witchcraft Suppression Act (3 of 1957) is only partially applied to make prosecutions and to obtain convictions. It confirms that the Witchcraft Suppression Act (3 of 1957) does not in general discriminate against the traditional
healer for wrongdoing as possible activated by the Traditional Health Practitioners Act (22 of 2007).

It seems from the outcomes of this subdivision that the Witchcraft Suppression Act (3 of 1957) benefits to society and the individual overshadow its prejudice. The view that the Act is only in part applied and then only to bring true criminality to book, supports the opinion that the constitutional rights of the individual or even the group are not transgressed. These outcomes seem to explain why the SALRC and the government itself are hesitant to repeal it, seeing that the Act fulfils its main aims to protect the individual.

5.4.6 The Traditional Health Practitioners Act (22 of 2007) and its intentions in perspective

With reference to the Traditional Health Practitioners Act’s (22 of 2007) rules, the practice of the traditional healer is determined in terms of two definitions, namely the definitions traditional health practice and traditional philosophy in Chapter 1 of the Act. Traditional health practice means the following: “The performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice”, while traditional philosophy incorporates the following sub-definitions:

- indigenous African techniques;
- indigenous African principles;
- indigenous African theories;
- indigenous African ideologies;
- indigenous African beliefs;
- indigenous African opinions;
- indigenous African customs; and
- the uses of traditional medicine communicated from ancestors to descendants; or
- from generations to generations, with or without written documentation, whether supported by science or not.

It is clear, although it is not described as such, that the supernatural plays a dominant role in the traditional health practice as the reference “communicated from ancestors to descendants” in the definition clearly indicates a traditional philosophy. This mentioned role of the supernatural in the
practice of the traditional healer is specifically supported by the definitions indigenous African theories, ideologies, beliefs, principles, opinions and customs as described in the traditional philosophy. The reference to “the existence of traditional medicine without written documentation, whether supported by science or not”, brings the presence of occult science in the traditional practice of the traditional healer to the foreground.

5.4.7 **The healer’s activities in perspective**

The Traditional Health Practitioners Act’s (22 of 2007) definitions of traditional health practice and traditional philosophy fail to offer formal, thorough descriptions on the diagnosis and treatment processes of the traditional healer and therefore any doings that can be in conflict with the Witchcraft Suppression Act (3 of 1957). To overcome this lack in information and to reflect on the diagnosis and treatment processes of the traditional healer, the descriptions offered by 13 independent researchers and experts on the traditional healer’s practice in South Africa are compiled below. This made it possible to profile the true diagnosis and treatment of the traditional healer and to use it as a guideline to evaluate the possibility of the transgression of the regulations of the Witchcraft Suppression Act (3 of 1957). This profile of the 13 researchers (identified by names) is reflected in Table 5.3.

5.4.8 **Possible supernatural practice activities and legal transgression of the stipulations of the Witchcraft Suppression Act (3 of 1957) by traditional healers**

To obtain a decision if the traditional healer’s diagnoses, treatment and training practices contravene the 14 offence rules of Section 1 of the Witchcraft Suppression Act (3 of 1957), these 14 offences are reflected under in Table 5.3 (see also Table 5.2) against the specific descriptions by the 13 researchers.¹⁵-²⁷ The researchers’ names are reflected in Table 5.3 when they refer to processes that correlate with the actions of the traditional healer.¹⁵-²⁷

From Table 5.3 it is clear that in only four out of 14 (28.5%) offences were the traditional healers not implicated, namely on the offence to indicate another person as a "wizard" (nr 2), employs or solicits a witch, witch-finder, etc., to name or to indicate another person as a "wizard" (nr 6), advises another person to bewitch, injure or damage another person (nr 8), and the use of advice by a witchdoctor, witch-finder, etc. to injure or to damage any other person (nr 10).

Regarding the correlations between the offences and the descriptions of researchers as reflected by Table 5.3, as much as 71.4 per cent of the descriptions indicate that there can be transgressions of the Witchcraft Suppression Act’s (3 of 1957) 14 criteria for offences. The 13 the
researchers reflect overlapping between the practice processes of the traditional healer and the offences of Section 1 of the Witchcraft Suppression Act (3 of 1957).

5.5 DISCUSSION

The traditional healer’s image of himself as only “good” against the witch as only “bad,” erroneously created by the Witchcraft Suppression Act (3 of 1957), is wrong and opportunistic. The evidence is overwhelming that their practice processes are based on the supernatural that they profess and indicate that they use supernatural powers, that they do fortune-telling, occult science, supply clients with means of witchcraft and that they intend to harm, injure and even kill other people. The 1957 identification of the witch as a sole entity and as a reality is therefore incorrect. There is no guarantee whatsoever that the traditional healer is not involved in witchcraft-related crimes, like ritual-, muti-, religious-, cultural – and revenge-murders. The researchers who point out that the traditional healer has involvement with in the police, politics, religion, as the real culprits to commit witchcraft-crimes, are therefore not far-fetched.4,11,28

It is clear that the Traditional Health Practitioners Act (22 of 2007) was promulgated without a thorough understanding of the offences listed in Act No 3 (1957). Basically the Witchcraft Suppression Act (3 of 1957), as confirmed by this research (see Table 5.3), renders the Traditional Health Practitioners Act’s (22 of 2007) null and void. It is time that the lawmakers revisit the Traditional Health Practitioners Act’s (22 of 2007) to look at its legitimacy as a law.

The Witchcraft Suppression Act (3 of 1957) is of cardinal importance to counteract the dangers of the traditional healer’s practices. It is an important criminal law; it is constitution-friendly and therefore cannot be repealed. Indeed, it can be made more comprehensive to combat the crime-intention of the traditional healer. The Traditional Health Practitioners Act’s (22 of 2007) in comparison is an improper Act that offers opportunities for criminal behaviour and it must be repealed because it is in conflict with the Witchcraft Suppression Act (3 of 1957).

It is clear that the Traditional Health Practitioners Act’s (22 of 2007) was meant for an established healthcare profession, one with clearly defined, legal-corrected practice processes. The traditional healers failed all the standard rules that a statutory healthcare profession should adhere to. It interferes with the privileges and rights of the already registered health professions. The Act also confirms that the traditional healer’s entrance into the established health sector of the country to practice a health service he is not trained for or capable to execute, was a mistake.

The Witchcraft Suppression Act (3 of 1957) reflects further shortcomings of the Traditional Health Practitioners Act’s (22 of 2007) and the doubtful status of the traditional healer as a “good” health
practitioner. It indeed confirms that some of the beliefs and activities of the traditional healer are based on the supernatural, future-telling and even occult science, etc., all outcomes that are illicit in terms of the Witchcraft Suppression Act (3 of 1957).

5.6 CONCLUSION

The Witchcraft Suppression Act (3 of 1957) is not discriminative against the practice behaviour of the traditional healer or the regulations of the Traditional Health Practitioners Act (22 of 2007), which determines the professional status of traditional healing in South Africa. To the contrary, the Witchcraft Suppression Act (3 of 1957) is very accommodating of the misbehaviour and malpractice of the traditional healer.

Some of the Traditional Health Practitioners Act’s (22 of 2007) regulations seem to stand in conflict with some of the regulations of the Witchcraft Suppression Act (3 of 1957), while the traditional healer’s practice activities seem to violate some of the regulations of the Witchcraft Suppression Act (3 of 1957), which determines criminal behaviour.

The Traditional Health Practitioners Act’s (22 of 2007) is an improper act, an unacceptable reality in modern-day South Africa. It must be repealed and not the Witchcraft Suppression Act (3 of 1957). The Traditional Health Practitioners Act’s (22 of 2007) seems to be a true dolus eventualis case for the South African Constitutional Court in the near future.
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Table 5-1: Six offences relating to witchcraft versus types of witchcraft-related convictions for the period 1994 to 2004

<table>
<thead>
<tr>
<th>Description of Offences</th>
<th>Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Any person who 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</td>
<td>Convictions</td>
</tr>
<tr>
<td>2 Any person who 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</td>
<td>None</td>
</tr>
<tr>
<td>3 Any person who employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard</td>
<td>Convictions</td>
</tr>
<tr>
<td>4 Any person who professes a knowledge of witchcraft, or the uses 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</td>
<td>None</td>
</tr>
<tr>
<td>5 Any person who on the advice of any witchdoctor, 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</td>
<td>Convictions</td>
</tr>
<tr>
<td>6 Any person who 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</td>
<td>None</td>
</tr>
</tbody>
</table>
Table 5-2: Fourteen offences relating to witchcraft versus types of witchcraft-related convictions for the period 1994 to 2004

<table>
<thead>
<tr>
<th>Description of Offences</th>
<th>Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any person who imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing</td>
<td>None</td>
</tr>
<tr>
<td>2. Any person who names or indicates any other person as a wizard</td>
<td>Convictions</td>
</tr>
<tr>
<td>3. Any person who in circumstances indicating that he professes any supernatural power, witchcraft, sorcery, enchantment or conjuration</td>
<td>None</td>
</tr>
<tr>
<td>4. Any person who in circumstances indicating that he pretends to use any supernatural power, witchcraft, sorcery, enchantment or conjuration</td>
<td>None</td>
</tr>
<tr>
<td>5. Any person who 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</td>
<td>None</td>
</tr>
<tr>
<td>6. Any person who employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard</td>
<td>Convictions</td>
</tr>
<tr>
<td>7. Any person who professes a knowledge of witchcraft, to bewitch, injure or damage any person or thing</td>
<td>None</td>
</tr>
<tr>
<td>8. Any person who advises any person with any pretended means of witchcraft</td>
<td>None</td>
</tr>
<tr>
<td>9. Any person who supplies any person with any pretended means of witchcraft</td>
<td>None</td>
</tr>
<tr>
<td>10. Any person who on the advice of any witchdoctor, witch-finder or other person 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</td>
<td>Convictions</td>
</tr>
<tr>
<td>11. Any person who 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</td>
<td>None</td>
</tr>
<tr>
<td>12. Any person who for gain pretends to exercise or use any supernatural power, witchcraft, sorcery, enchantment or conjuration</td>
<td>None</td>
</tr>
<tr>
<td>13. Any person who for gain undertakes to tell fortunes</td>
<td>None</td>
</tr>
<tr>
<td>14. Any person who for gain pretends from his skill in or knowledge of any occult science to discover where and in what manner</td>
<td>None</td>
</tr>
<tr>
<td>Description of Offences</td>
<td>Names of Researchers</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1 Any person who imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing</td>
<td>Essien, 2013; Hofstatter, 2014; “Traditional African medicine,” 2014; Truter, 2007</td>
</tr>
<tr>
<td>2 Any person who names or indicates any other person as a wizard</td>
<td>None</td>
</tr>
<tr>
<td>5 Any person who imputes the cause of death of, injury or grief to, disease in, damage to or disappearance of any person or thing</td>
<td>Hofstatter, 2014; Truter, 2007</td>
</tr>
<tr>
<td>6 Any person who employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard</td>
<td>None</td>
</tr>
<tr>
<td>7 Any person who professes a knowledge of witchcraft, to bewitch, injure or damage any person or thing</td>
<td>Hofstatter, 2014; “Traditional African medicine,” 2014; Truter, 2007</td>
</tr>
<tr>
<td>8 Any person who advises any person with any pretended means of witchcraft</td>
<td>None</td>
</tr>
<tr>
<td>9 Any person who supplies any person with any pretended means of witchcraft</td>
<td>Hofstatter, 2014; Truter, 2007</td>
</tr>
<tr>
<td>10 Any person who on the advice of any witchdoctor, witch-finder or other person 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</td>
<td>None</td>
</tr>
<tr>
<td>11 Any person who 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</td>
<td>Hofstatter, 2014; “Traditional African medicine,” 2014; Truter, 2007</td>
</tr>
<tr>
<td>Description of Offences</td>
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<tr>
<td>13 Any person who for gain undertakes to tell fortunes</td>
<td>Essien, 2013; “South African Traditional,” 2014</td>
</tr>
<tr>
<td>14 Any person who for gain pretends from his skill in or knowledge of any occult science to discover where and in what manner</td>
<td>“South African Traditional,” 2014; “Traditional healers of,” 2014; Truter, 2007</td>
</tr>
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DESCRIPTION OF INFORMATION TRANSFERRED FROM CHAPTER 5 TO CHAPTER 6

The Act to regulate the traditional health fraternity was pursued since the 1960s and became a reality after the 1994 political dispensation. Although the Act was already promulgated in 2007, it is still not active. Certain definitions in the Act are very controversial; especially the role of the supernatural in healing, which could be associated with witchcraft and criminal behaviour. From the data extracted from various sources it seems as if the Traditional Health Practitioners Act (22 of 2007) was promulgated without a thorough research on the role that the traditional healer can play in witchcraft activities. The aim of the Witchcraft Suppression Act (3 of 1957) was totally ignored. The Witchcraft Suppression Act (3 of 1957) does not discriminate against the Traditional Health Practitioners Act (22 of 2007). Instead, it seems that various stipulations of the Witchcraft Suppression Act (3 of 1957) are frequently transgressed by the traditional healers without legal action being taken against them.

It is clear that the supernatural plays a dominant role in traditional health practice. This role of the supernatural in the practice of the traditional healer is specifically supported by the definitions indigenous African theories, ideologies, beliefs, principles, opinions and customs as described in the traditional philosophy. The reference to “the existence of traditional medicine without written documentation, whether supported by science or not”, brings the presence of occult science in the traditional practice of the traditional healer to the foreground.

The traditional healer’s image of himself as only “good” against the witch as only “bad”, erroneously created by Act the Witchcraft Suppression Act (3 of 1957), is wrong and opportunistic. The evidence is overwhelming that their practice processes are based on the supernatural, that they profess and indicate that they use supernatural powers, that they do fortune-telling, occult science, supply their clients with means of witchcraft and that they intend to harm, injure and even kill other people. The 1957 identification of the witch as a sole entity and as a reality is therefore incorrect. There is no guarantee whatsoever that the traditional healer is not involved in witchcraft-related crimes, like ritual-, muti-, religious-, cultural – and revenge-murders.

It is clear that the Traditional Health Practitioners Act (22 of 2007) was promulgated without a proper understanding of the offences listed in the Witchcraft Suppression Act (3 of 1957). Basically the Witchcraft Suppression Act (3 of 1957), as confirmed by this research (see Table 5.3), renders the Traditional Health Practitioners Act (22 of 2007) null and void. It is time that the lawmakers revisit the Traditional Health Practitioners Act (22 of 2007) to look to its legitimacy as a law.
From Chapter 5 it is clear that the Traditional Health Practitioners Act (22 of 2007) was meant for an established healthcare profession, one with clearly defined, legally corrected practice processes. The traditional healers have failed all the standard rules required by a statutory healthcare profession. It interferes with the privileges and rights of the registered health professions. The Act also confirms that the traditional healer’s entrance into the established health facilities of the country to practice a health service he is not trained for or capable to execute, was a mistake.

Chapter 5 clearly shows that the Witchcraft Suppression Act (3 of 1957) reflects further shortcomings of the Traditional Health Practitioners Act (22 of 2007) and the doubtful status of the traditional healer as a “good” health practitioner. It indeed confirms that some of the beliefs and activities of the traditional healer are based on the supernatural, future-telling and even occult science, etc., all outcomes that are illicit in terms of the Witchcraft Suppression Act (3 of 1957). The Traditional Health Practitioners Act’s (22 of 2007) regulations seem to stand in conflict with some of the regulations of the Witchcraft Suppression Act (3 of 1957), while the traditional healer’s practice activities seem also to violate some of the regulations of the Witchcraft Suppression Act (3 of 1957), which determines criminal behaviour. The Traditional Health Practitioners Act (22 of 2007) does not edify the present-day official healthcare sector in any way.

The third of the five articles is titled: The Traditional Health Practitioners Act (22 of 2007): A South African Constitutional mistake? The article tests the hypothesis that the Act edifies the present-day healthcare sector. This is scrutinized further in Chapter 6, which addresses the Act’s legal standing in terms of the Constitution of South Africa. The basic test is to see if it is in conflict with the Constitution and if it is appropriate as a healthcare legislation.
CHAPTER 6

THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007): A SOUTH AFRICAN CONSTITUTIONAL MISTAKE?

(Article 3)

Authors: Louw, G. P. & Duvenhage, A.


ABSTRACT

The Traditional Health Practitioners Act (22 of 2007), which has elicited controversy in the South African healthcare and public sector since proclamation, went untested, driven by the post-1994 socio-political dispensation. No previous in-depth studies have been identified. The Act was promulgated without an applicable and appropriate scientific needs-analysis. The Act is in conflict with the Constitution to some extent, as well as with various other Acts, like the Witchcraft Suppression Act (3 of 1957). Nearly a decade after promulgation, the Act is still not fully active. It is a constitutional mistake. Notwithstanding its constitutional controversy, the Act’s political sanction by governmental agencies and political leaders will ensure that it will not vanish easily from the South African law books.

Keywords

Apartheid, constitution, human rights, post-1994 dispensation, traditional healer and religions
6.1 BACKGROUND

The Act was shaped by two strategy manifestos of the ANC, namely the Manifesto of the National Democratic Revolution (NDR) of 1969 and the National Health Plan (NHP) of 1994. Never has the ANC deviated an inch from these master plans in the execution of political and cultural preferences over the years, notwithstanding sound logical, legal and financial arguments against it. This fixed viewpoint has distorted thinking around the true rights of individuals and groups, democracy and the correct interpretation of the various clauses of the Constitution.¹⁻¹³

6.2 AIMS AND OBJECTIVES

The aim of this study was to determine and to reflect on the Act’s long-term legal implications for the statutory recognized health professions and the public, specifically with the focus on the Constitution and other legislations.

6.3 METHOD

Books and articles on South African traditional healing are very limited; it offers mostly trivial, old, and superficial information.¹⁴ This lack of sound and in-depth research findings on the traditional healer in South Africa necessitated a literature review that builds a viewpoint and forms a conclusion based on the evidence as it appears as the research develops. The exploratory and descriptive research approach, as used in modern-day historical studies of investigation and reviewing information, was the most appropriate. Contemporary newspapers, reports and articles were used as primary resources to reflect on the impact of the Act and traditional healing on specifically the functioning of the Constitution and the present-day life of South Africans.¹⁵⁻¹⁶

The findings are offered in narrative form.

6.4 RESULTS

6.4.1 The Traditional Health Practitioners Act (22 of 2007) is still untested today

The formulation of the Act is a good example of the general thought on the traditional healer’s competence since 1960 and the political influence on this matter. There was never an in-depth study to determine the true need for and applicability of the Act. The problem was side-stepped with two superficial enquiries, supported by various insignificant road shows between 1997 and 1998.¹⁻³,¹⁷⁻²³
The final decision to formulate the Act was based on the outcome of five basic questions that were put to the public randomly.\textsuperscript{1,3,17, 18,23,24,25,26,27}

They are:

- The desirability of a statutory council for traditional healers;
- The recognition of medical certificates issued by traditional healers;
- The recognition of the claims of traditional healers by medical schemes;
- The formal legal recognition of traditional healers as a medical source;
- The establishment of an Interim Council for the regulation of traditional healers as a health profession.

Negative indicators about the traditional health practitioner’s future statutory recognition in terms of the Act and the future regulation of traditional healing as a formal healthcare sector, were not thoroughly considered in the proposal of the Act. Several problems were ignored, such as the lack of a need for traditional healers, various non-described types of traditional healers in practice, a lack of formal training programmes, training standards and a functioning system, the risks that the traditional treatments and concoctions hold for the public and the health sector, the negative effect of the traditional healer on the practices of the already statutorily recognized health practitioners, especially medical doctors, as well as a lack of proper research on the possible negative role to play in healthcare. There was no consideration of how to incorporate the traditional healer into the established allied professions, like homoeopathy, naturopathy, phytotherapy and ethno-medicine, and to avoid duplication in training and health practitioner types, as well limiting the immense development costs around the separate recognition of the traditional healer.\textsuperscript{1-3,5,11,17,18,28-43}

This legalization of traditional healing and its inclusion in the established health sector was pursued under the banner of Section 31(1) of the Constitution of South Africa. This regulation declares that no person who belongs to a cultural community may be denied the right to enjoy their culture with the other members of that community. Proponents of traditional healing interpret this clause as bestowing unchallengeable constitutional rights on the traditional healer to practice his trade. The logical next step of the argument is that the community of the healer has the right to demand his services as a traditional healer.\textsuperscript{45,44-46}

The above belief confirmed and supported by the \textit{Patients Charter 2002} of the DOH. This Charter emphasizes the right of patients to be free to choose a particular type of healthcare practitioner
for services, notwithstanding the risk that the practitioner may pose to the individual or to healthcare in general. It seems in this context as if the Charter itself was a constitutional failure.\textsuperscript{10,18,25,47-51}

6.4.2 Transgression of the law by offering official work and training appointments to traditional healers

The above opportunistic and scornful attitudes about the alleged rights and status of the traditional healer as reflected inside and outside the traditional healthcare setup, led to a situation where various governmental, semi-governmental and other agencies and bodies even signed legal agreements with traditional healers to work in an official health team or to formally train traditional healers. Examples of these agreements include a well-known university and two prominent municipalities. One of these municipalities appointed traditional medicine managers to integrate traditional healing and allopathic medicine in its health system and to promote two-way referrals and collaboration between the municipality’s clinics and traditional healers. The university is alleged to have a traditional healer on its staff, working in its counselling and wellness programme. These actions are alarming and irresponsible; they are risky and must be evaluated against the Constitution’s Human Rights Manifesto.\textsuperscript{10, 24, 25, 31, 44, 45, 47, 51-53}

In retrospect, it must be noted that although the Act has been promulgated, it has not been fully enacted at this stage (2017). There is still no functioning register for traditional healers. It is therefore still illegal, in terms of the various health acts, for the registered healthcare practitioners to work with the unregistered traditional healer. Anybody, whether a municipality, university or individual doing so is putting the health and life of their patients at risk and will not have any indemnity in lawsuits for malpractice with this behaviour.\textsuperscript{30,44,54-57}

6.4.3 Subtle abuses of legal definitions in self-promotion

The law is furthermore transgressed indirectly in the abuses of certain clauses of the Constitution, the Civil Union Act (17 of 2007), as well as the Traditional Health Practitioners Act (22 of 2007) when individuals in the traditional fraternity present themselves to the public as skilled and therefore acceptable as part of the statutory healthcare.

The actions of certain traditional healers’ organizations reflect these abuses of the Constitution very well in their public ethics declarations and practice rights communications. Specific are those clauses hauled in under the traditional healing umbrella of “exclusive rights to practice,” with the misleading prefix in the Constitution that stipulates that “everyone has a right to equality, human dignity, free association, privacy, religion, beliefs and opinions, trade preferences, occupations
and professions, preference life-styles, fair labour practices and access to preferred healthcare”, notwithstanding that they know very well that these clauses are not fully applicable to the traditional healers’ unscientific and risky practices.

These legal abuses are very subtly reflected in traditional health fraternity communications. They try to pass off the Act’s description of the representative of the HPCSA on the THPCSA as formal recognition of traditional healing by the medical and pharmaceutical fraternities. The impression is created that the HPCSA and SAPC recognize the traditional healers as independent health practitioners. In actual fact, traditional healers know very well that these representatives who sit on the THPCSA are required by Section 7 of the Act to oversee the processes so that the THPCSA and its practitioners do not violate the legal rights and privileges of the recognized health practitioners.

6.4.4 **Constitutional abuses have limits, even for the traditional healer in the new South Africa**

Constitutional abuses have limits; traditional healers cannot simply practice as they feel. First, they are still unregulated practitioners who are clearly violating many of the country’s health laws and as such must be controlled. Second, other citizens of South Africa also have rights, privileges and freedoms equal to that of the traditional healer that must be protected. Sections 12(2) and 32(1) (b) of Act No 108 of 1992, a pre-1994 version of the Constitution, are clear and loud about this.

There is great difference between private and public rights, with the last-mentioned being favoured. The differences and uniqueness of individuals in terms of culture, person, finance and lifestyles cannot be addressed or solved by abuses of the Constitution, as the government blindly did with the promulgation of the Act and the official recognition of the traditional healer. Not even the Constitution can bring equality, as the academic and activist, Dr Danny Titus, clearly points out when he states that South Africans cannot argue away their true differences with the argument that everyone is equal before the law: South Africans are just too unequal and need another address for individual rights.

The Nobel laureate Milton Freedman warned long ago that a society that considers equality higher than the individual’s freedom [in this case safe medicines versus medical concoctions], will end without any one of the two.

It seems as if there is confusion in the minds of the post-1994 government about equality for every South African and cases where care should be taken when conferring such a right. It is ill-
considered to give unlimited rights to a specific individual, in this case the traditional healer, knowing well that the person can be a danger to the health of others.\textsuperscript{5,59-64}

Constitution experts, Prof. Marinus Wiechers and Prof. Koos Malan, identified this situation where the law-abiding, good and sound person’s rights and claims are sacrificed to serve a pretended ideal state of equality. Malan pinpoints this pretended equal state not as a correction-action-state, but as a consuming-governmental-state. The intention is the disregard of all the rights and claims of the good as well as the problematic individual. This devastator, it seems, is now inside formal healthcare in terms of the Act.\textsuperscript{62-64}

6.4.5 The Traditional Health Practitioners Act (22 of 2007) is political oriented, not culturally

Proponents of traditional healing argue that traditional healing is an essential cultural demand by South African society, free of politics. The NDR (1969) contradicts this free of political meddling argument. This political document, which gave birth to the Act and was formulated in the Apartheid regime’s most notorious time of the suppression of the South African majority, clearly had as an aim and a vision the establishment of pro-African healthcare services and institutes, one that includes traditional healing.\textsuperscript{1-3,6,8,10-13,17,24,28,29,33-38,49,65,66}

The whole 1969-thinking was executed by a small, exiled political leadership, who thought themselves able to think on behalf of the voiceless and vote-less majority at home; an autocratic decision-making, possibly acceptable for the majority in that time of suffering and uncertainty. But the demise of apartheid in 1994 and the end of barriers on political, economical, educational and healthcare brought political rights in decision-making directly to the majority. These changes also brought mind shifts away from the 1969 autocratic leadership’s thinking, especially on the outdated healthcare, cultural and political thinking of 1969. South Africans, now free to think as they choose, have become modern, also in their healthcare use. Traditional healing, together with other pre-modern remnants of healings and religions, disappeared from their mind-sets.\textsuperscript{64,68-75,1257}

The 1969-leadership, now elders but with some still in political power, have failed to change and to hang on to outdated and warped thinking on the supernatural, witches and traditional healing; not only because they believe in it, but primary because they see it as something that they can use to stay in power and to serve their own interests. The Act is such a political behaviour, notwithstanding that these leaders knowingly transgress Article 16 of the Constitution and the Code of Ethics for Members of the Executive, as prescribed by the Ethics Act (82 of 1990).\textsuperscript{4,49,51,55,67,76-87}
6.4.6 Is the Traditional Health Practitioners Act (22 of 2007) a failure in terms of the Constitution?

The Act was a well-planned legal and promotion exercise that aimed to bring the pre-modern traditional healer into the formal health sector as an equal to the modern-day health practitioner. This forcing down of the traditional healer onto the masses also shows the official disregard for the poor, uneducated individual, who is not only deprived by the government of medical and life aids, but is now also left with the unscrupulous traditional healer and dangerous concoctions.4,49,51,55,67,76-87

Only the post-1994 government’s immediate personal and political interests are served with the recognition of the traditional healer: its recognition as a specific healer is not equal to the upliftment of the poor or uneducated individual. Uplifting, equality and non-discrimination are three separate concepts. When viewed as one construct, upliftment and non-discrimination are prerequisites for equality, and it should not be the ill-considered equality of the government. Stretching certain clauses of the Constitution, the Act and other legal rules to promote and to establish traditional healing, is dangerous.49,59,62-64,88-90

The present constitutional mistake in terms of the South African political-legal system cuts to the heart of a society still under construction. This mistake forced emeritus judge Bernard Ngoepe to react on how the Constitution is misunderstood, misused and disrespected by saying that some South Africans think that the Constitution gives them rights without limitations, an excuse through which they can get everything for nothing. It is clear for Ngoepe that some South Africans, the public as well as politicians, have a problem in the way they understand and apply the Constitution. The Act and traditional healing is surely such an example.91,92

6.4.7 Past opposition to the Traditional Health Practitioners Act (22 of 2007)

Opposition to the Act has thus far been minimal, notwithstanding the serious consequences it holds for the established health practitioners, especially medical doctors. This poor reaction to the Act can be ascribed to various obstructions:

First, criticism on the government is either choked or ignored and executive decisions are taken one-sidedly, basically by the overpowering majority of the ANC in the Parliament.18,21,49,89

Second, criticism from especially journalists and academics is strong, but with very little positive effect. In this regard there is always the fear of victimization. At the moment the objections are
just not strong enough to bring a turn-around. More organized actions are needed, but the question is what really can be done to nullify the Act. 93-96

6.4.8 Possible future actions against the Traditional Health Practitioners Act (22 of 2007)

6.4.8.1 Submissions to Parliament

It is doubtful if any sympathy would be found in Parliament and its lawmakers for the repealing of the Act, seeing that they put the present Act through Parliament in 2003 and did nothing to oppose it. The present ANC-led government's disrespect for the Constitution and basic rights on health safety, as the traditional healer demonstrates, together with rejections of appeals to rectify one-sided decisions, will surely make any direct appeal by the medical fraternity to Parliament on the Act useless. This concern is confirmed by the action of Parliament to ignore the legal presence of the Witchcraft Suppression Act (3 of 1957) when promulgating the Act. They also gave no consideration to the rights of other medical practitioners. 77,96-108

The fact that the present ANC-government is going to stay in power for at least another 20 years, confirms that the Parliament is not an ideal avenue. 61,109-113

The fact that some of the top members of the government themselves believe in the supernatural and in interference by the ancestors, in itself rules out any anti-action in Parliament against the Act. 78,114

It must further be remembered that the public has lost faith in the Parliament to solve their problems. This is confirmed by two research polls, namely the 2014 IPSOS-Poll and 2014 Media 24-Poll. These studies show that between 53 per cent and 89 per cent of the population distrust the Parliament and government. Taken action and taking on the Parliament on the Act seems to be worthless. 114-118

6.4.8.2 Court actions

Another option to take on the Act and the present-day government is direct court action. So far the Act went unchallenged in court, although it violates the rights and practices of the statutory health professions. In this regard, it is important to note that South African Courts are not very willing to give judgments on controversial political and cultural issues. Here, the medical fraternity's own sad experience with the DFL's legal action in 2003 with the Traditional Health Practitioners Bill, is still too fresh in their minds to readily re-engage in court actions. 61,84
Similar to the above-mentioned negative experience of the DFL, it must be noted that a 2014 Media 24-Poll found that as much as 78 per cent of the population does not trust South African Courts fully. This negative inclination surely also affects the medical fraternity to rethink before they decide to take on the Act in a legal battle. As learned from the DFL-case, the outcome can be negative for them.  

The hesitation of the medical fraternity to take legal actions must also be seen from the point that the Act is still in limbo and can therefore not effectively be taken to court. The implementation of certain sections of the Act was only done on 1 May 2014 and was limited to the establishment of the Interim Traditional Health Practitioners Council and the provision of a regulatory framework to ensure the efficacy and quality of traditional core services. This limits legal reaction. Recourse to courts of law by the medical fraternity is therefore difficult at this stage, seeing that there is no real legal and physical threat. As soon as the traditional healer enters the health services and establishment and makes him/her guilty of improper behaviour, organized court actions from the medical profession can be expected.  

6.4.8.3 **Informal ways to address the Act**

Thus far healthcare practitioners have not been doing well with addressing their own professional dilemmas, it is doubtful that there could be an internal solution. It is clear that ways must be found outside the formal avenues to address the Act. Not only individual, but also class actions are needed. This will involve public and private media and in-depth research on the Act, traditional health and its impact on the healthcare sector. Strikes and walkouts, common and effective in South Africa, seem a very appropriate and effective alternative for the allopathic practitioners to be followed.  

6.5 **DISCUSSION**

It is the duty of the South African government to ensure that a specific healthcare or spiritual practitioner, in this case the traditional healer who is at most a spiritual caregiver, does not transgress any established laws in his practice, either against the individual or a group. Care should be taken that the health practitioner does not endanger the health or the life of the patient or client. In the case of the Act, these prerequisites are not in place. Never in South Africa’s history was statutory healer status awarded to priests, nor have religious groups ever been regulated.  

The Act is one of the many inapplicable, inappropriate and unworkable acts that were put through Parliament since 1994. Prof Piet Naude, director of the University Stellenbosch Business School (USB) remarks that our politicians do not always have respect for Parliament and that they make
Acts that do not pass the test and that have to be revised again and again. The fact that the Act is still not fully functional, although promulgated in 2007, confirms that it had not passed the test of good legislation, even today.\textsuperscript{118, 119}

6.6 CONCLUSION

The Act is an improper healthcare act, a failure when evaluated against the Constitution. Due to the high level of political sanctioning it receives, the Act stands firm and it must be accepted that it will not be comprehensively revised or repealed, in the next 10 to 20 years.

Further abuses of the Constitution by the traditional healer fraternity with stronger official sanctioning can be expected.
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DESCRIPTION OF THE INFORMATION TRANSFERRED FROM CHAPTER 6 TO CHAPTER 7

The law is furthermore transgressed indirectly in the abuses of certain clauses of the Constitution, the Civil Union Act (17 of 2007), as well as the Traditional Health Practitioners Act (22 of 2007) when individuals in the traditional fraternity present themselves to the public as skilled and therefore acceptable as part of the statutory healthcare.

The actions of certain traditional healers’ organizations reflect these abuses of the Constitution very well in their public ethics declarations and practice rights communications. Specific are those clauses hauled in under the traditional healing umbrella of “exclusive rights to practice”, with the misleading prefix in the Constitution that stipulates that “everyone has a right to equality, human dignity, free association, privacy, religion, beliefs and opinions, trade preferences, occupations and professions, preference life-styles, fair labour practices and access to preferred healthcare”, notwithstanding that they know very well that these clauses are not fully applicable to the traditional healers’ unscientific and risky practices.  

These legal abuses are very subtly reflected in traditional health fraternity communications. They try to pass off the Act’s description of the representative of the HPCSA as formal recognition of traditional healing by the medical and pharmaceutical fraternities. The impression is created that the HPCSA and SAPC recognize the traditional healers as independent health practitioners. In actual fact, traditional healers know very well that these representatives who sit on the THPCSA are required by Section 7 of the Act to oversee the processes so that the THPCSA and its practitioners do not violate the legal rights and privileges of the recognized health practitioners.

Constitutional abuses have limits: traditional healers cannot simply practice as they feel. First, they are still unregulated practitioners who are clearly violating many of the country’s health laws and as such must be controlled. Second, other citizens of South Africa also have rights, privileges and freedoms equal to that of the traditional healer that must be protected. Sections 12(2) and 32(1) (b) of Act No 108 of 1992, a pre-1994 version of the Constitution, are clear and loud about this.

There is great difference between private and public rights, with the last mentioned being favoured. Differences and uniqueness in culture, person, finance and lifestyles between South Africans, cannot be addressed or solved by misuses of the Constitution, as the government blindly did with the promulgation of the Act and the official recognition of the traditional healer. Not even the Constitution can bring equality: South Africans are just too unequal and need another address
for individual rights. It seems as if there is confusion in the minds of the post-1994 government about equality for every South African and cases where care should be taken when conferring such a right. It is ill-considered to give unlimited rights to a specific individual, in this case the traditional healer, knowing well that the person can be a danger to the health of others.\textsuperscript{5,59-64}

This pretended equal state is not a correction-action-state, but a consuming-governmental-state. The intention is the disregard of all the rights and claims of the good as well as the problematic individual. This devastator, it seems, is now inside formal healthcare in terms of the Act. The Act was driven by the ANC regime, knowingly transgressing Article 16 of the Constitution and the Code of Ethics for Members of the Executive, as prescribed by the Ethics Act (82 of 1990).

Only the post-1994 government’s immediate personal and political interests are served with the recognition of the traditional healer: its recognition as a specific healer is not equal to the upliftment of the poor or uneducated individual. \textit{Uplifting, equality and non-discrimination} are three separate concepts. When viewed as one construct, upliftment and non-discrimination are pre-requisites for equality, and it should not be the ill-considered equality of the government. Stretching certain clauses of the Constitution, the Act and other legal rules to promote and to establish traditional healing, is dangerous.

The finding that the Act is a mistake when regarded from the perspective of the Constitution cuts to the heart of a society still under construction. Chapter 6 shows that the Act does not support the present-day official healthcare sector in any way.

The fourth of the five articles is titled: The Traditional Health Practitioners Act (22 of 2007): A godsend or a curse for South Africa’s healthcare?, tests in Chapter 7 the hypothesis that the Act edifies the present-day healthcare sector.
CHAPTER 7

THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007): A GODSEND OR A CURSE FOR SOUTH AFRICA’S HEALTHCARE?

(Article 4)

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ABSTRACT

South Africa’s development and growth in healthcare since the 1900s is phenomenal, but certain present-day healthcare policies such as the Traditional Health Practitioners Act (22 of 2007), could jeopardize the progress. It seems that the Act was promulgated without comprehensive exploratory research and an in-depth consultation with all the role-players involved in South Africa’s healthcare, especially the statutorily registered health professionals. Political influences played a large part in the promulgation of the Act in 2007. In 2017 it is still not fully operational and the indication is that it will take years for the traditional health practitioner to become a full member of the health sector, if ever. This health Act can cause serious long-term disturbances for the established healthcare practitioners and the statutory healthcare sector.

Key Words

Traditional healer, traditional health, traditional philosophy, pre-modern, medical mixtures, public health, statutory status
7.1 BACKGROUND

South Africa’s healthcare system is supported by excellent laws that regulate its healthcare practitioners. These laws assure that the health practices, ethics and training of its practitioners are world class, and that the future development of the healthcare establishment and its services will at all times benefit South Africans.

The Act, with the sole aim of recognizing the traditional healer as a statutory health professional within the healthcare establishment, appears to reflect negative manifestations that could do healthcare serious damage. The Act elicited controversy when it was first promulgated in 2003 because it was seen as pre-modern health legislation for a modern society. Furthermore, it was not well researched with respect to the need for traditional health, the negative effect that it could have on general healthcare or established health professions and other long-term consequences. Neither was its level and standards of training ever properly debated.1-6

7.2 AIMS AND OBJECTIVES

The study aims to determine if the Act is a godsend to the South African healthcare or if there is an indication of doom.

7.3 METHOD

The research was done by means of a literature review. This method entails formulating a view based on the available research evidence. This approach is used in modern historical research where there is a lack of information on a topic. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for the period 1984 to 2014, articles from 1978 to 2016, books for the period 1990 to 2014 and governmental documents covering the period 1957 to 2015. These sources were probed to find out if the Act is a godsend or an act that spells doom for the South Africa’s healthcare.

The findings are offered in narrative form.

7.4 RESULTS

There are few fields within healthcare worldwide that elicit such controversy as traditional healthcare. South Africa’s traditional healthcare issue is therefore not an exception.

Much of the South African literature on traditional healthcare stretches over more than 50 years and offers various opinions, views, postulations, generalizations and myths about the good
nature, excellent healing abilities, distinctiveness and indispensability of the traditional healer. Literature for instance states that between 60 to 95 per cent of all South Africans regularly consult traditional healers before consulting modern doctors and that there are 200 000 traditional healers in practice compared to 30 000 medical doctors. Traditional healers are cited as an important national health resource and the literature claims that there is at present a dramatic evolution in “traditional medicine.” It is further cited that patients prefer the holistic treatment approach of the traditional healer above an allopathic one. It is stated that 60 per cent of South African babies are delivered by traditional attendants. The literature argues that the European/Western previous governments of South Africa have discriminated against indigenous healthcare, limiting its capacity. According to this argument, apartheid and White supremacy led specifically to the underdevelopment of traditional healing in South Africa.9-43

7.4.1 One-sided, superficial and unspecific research on traditional healing

An in-depth review of official and popular literature on South African traditional healing shows a very one-sided, superficial and unscientific research approach and reporting: one that is often based on repeated quotations of old, and not always trustworthy, information. Explicit descriptions and analyses, based on sound and in-depth research of historical events and facts, reliable and well-reported statistics and other supportive evidence to enlighten the role of the traditional healer, are completely missing from most literature.10-14

The unfounded claims of traditional healers that they act as a medium with the ancestral spirits; that they are able to interpret messages from the ancestors; that they can bring luck, fidelity, or make rain; that through their distribution of muti around and about the kraal, they can ward off lightening or cause the witch discomfort in her bad endeavours; that they can with muti destroy the powers in other people and can have people contract fatal diseases; are seemingly all accepted by the propagandists and many reporting researchers (mostly well-trained Europeans and Westerners) as true and good personal and practitioner’s talents.1-4,22,23

This point of view is maintained, notwithstanding the fact that it is false and in conflict with modern health therapy and treatment. It is also contrary to the Witchcraft Suppression Act (3 of 1957) as amended by Acts No 50 of 1970 and No 33 of 1997 of South Africa to combat the evil behaviour of the traditional healer. Mental impairment (especially the schizophrenic and the antisocial personality disorders), seemingly a major characteristic of the traditional healer, are accepted as normal. They are defined as essential parts of indigenous people’s culture. This view stretches an “African Culture” of South Africa as real and correct to excuse abhorrent behaviour. Even the Act defines the term traditional philosophy with the words “uses of traditional medicines
communicated from ancestors to descendants” as a normal part of life and mental phenomenon to be accepted unquestioningly by all South Africans because it is a formal part of the Act.\textsuperscript{44-50}

7.4.2 Well-structured introduction plan for traditional health since 1969

The introduction and presentation of the traditional healer to the general public of South Africa as a health practitioner has been well structured and planned, especially since 1994. Political and emotional rhetoric about the traditional healer and his “unique medicine” as a victim of colonial powers, the apartheid regime and the Western/European health fraternity, became standard remarks in speeches, articles and other publications.\textsuperscript{1-4,28,33}

Even the good name of various South African medical research bodies have been clouded by the South African traditional healers and their misleading statements about their alleged distinctive role in the manufacturing and sales of “traditional medicines”, or more specifically pre-modern medical products. General information, based on worldwide references, is falsified and used excessively and out of context for the South African scenario.\textsuperscript{3}

Compiling a trustworthy profile of the South African traditional healer and his medical products outside political and emotional rhetoric and other superficial literature like the above, is impossible. It is not possible to ascertain the number of members, levels of expertise, school and professional training, ethics, public needs and consultation ratios, or the ratio between Western healers and traditional healers. If the above descriptions and superficial literature are used, we will only arrive at falsities, like many South African studies on traditional healing already reflect. To put traditional healing in perspective, the Act must first be analysed and interpreted thoroughly as the starting point of research and discussion. Only after that can the assumptions, generalizations, deceptions and myths around it, be taken into account.\textsuperscript{5}

The post-1994 South African government, together with activists and propagandists of traditional healing, seem to have ensured that a multifaceted, multicultural and multi-cosmological context for health and mental healthcare delivery has come to pass; one that includes traditional healers, no matter the costs, risks and uncertainty that this entails. All legitimate objections against the traditional healer and the status of traditional healing as an official health service were ignored and trashed with a well-planned strategy, starting as early as the 1960s. The plan or strategy is clear, namely, to use the new democracy of South Africa as a vehicle to change remnants of the pre-1994 political, economic and social scenario, which included the establishment of a Western and European healthcare sector and the regulated health professions.\textsuperscript{10-13,23,51-62}
This perspective seems to reflect the fast-tracked process to recognize the traditional practitioners statutorily with the Act. There were precautions taken to avoid pitfalls. In connection with the above, it must be remembered that the hay-day of the political emancipation, that started in 1969 with the NDR of the ANC, was aimed at establishing a considerable degree of self-determination by indigenous South Africans, whether applicable or not. The postulation then was that health services should be based on a mixed socialist-capitalist economy and a socialized or nationalized form of healthcare services, open for service delivery to all. Internal inputs to the new health plan were led by the National Health Committee of the ANC, the United Democratic Front (UDF) and its affiliate, the National Alternative Medical and Dental Association (NAMDA), National Education Health and Allied Workers Union (NEHAWU), the Inkatha Freedom Party (IFP), the National Progressive Primary Health Care Network (NPPHCN) and DFL International. Very little has changed since then on this 1969 revolution master plan, nor has there been any consideration of its possible negative consequences.1,10-13,17,20,23,60,63,64

The ANC stated again in 1994 in its health plan, without offering any sound argumentation or facts, that indigenous cultural preferences, like traditional healing, would become an integral and recognized part of healthcare in South Africa. The basic view is that the consumer must have the right to choose a health practitioner, notwithstanding whether that health practitioner is the best for him or her or society as a whole in terms of training, risk, safety and know-how. To reach this objective, the ANC aimed to change health legislation to facilitate the controlled use of the traditional healer, but at the same time to take total charge of the entire healthcare and its regulated practitioners in South Africa.10-13,31,60

Foreign role-players in the promotion of traditional healers in South Africa were the African Union (AU), which, with its declaration in 2001 of the Decade of African Traditional Medicine, acknowledged the role played by traditional “medicine” and the need to integrate it into NHSs of African countries. The same is valid for the WHO, with its 1978 Alma-Ata Declaration of Primary Health Care, when it recognized and endorsed traditional “medicine.” This was followed by its Traditional Medicine Strategy 2002 to 2005 and various other WHO guidelines, which all emphasized the integration of traditional health into national healthcare in Africa.31,39-42,54,65,67-69

A massive infiltration into South Africa’s governmental law-making and executive agencies by traditional healers and their co-agents, is also evident.72 A good example of this in-depth infiltration was the remark in 2013 by the then Deputy Minister of Health when she stated that it is the government’s goal to integrate Traditional Health Medicine into the NHS as soon as possible. She also made known that many primary healthcare facilities and hospitals are already working with traditional health practitioners with governmental approval to contain childhood diseases like
diarrhoea and vomiting, HIV/AIDS and TB, mental illness and many others, as well that many traditional health practitioners sit on clinic committees, hospital boards, district health committees and provincial and national advisory structures. Objection and resistance to the Act were minimal and unimpressive. The fact that the Traditional Practitioners Bill of 2003 passed through Parliament in 2003 without a single objection or formal protest from a parliamentarian (either by the ANC as the ruler and the DA as the opposition), reflects the extreme and comprehensive emotional, political and cultural domination and drive to promulgate the Act at that time. The lack of objection was notwithstanding the fact that all the parliamentarians should have had knowledge of the future high costs to implement the Act, its lack of sound training, its negative effect on the health sector and the regulated health professionals, as well as the fact that it would take years to organize the traditional healers’ unorganized and undisciplined system.

7.5 DISCUSSION

The main issue for the post-1994 government has been the balancing act between sensitive “African” beliefs and customs, which were widespread among its loyal voters and supporters (however illogical, outdated and unscientific in comparison to modern scientific thinking, practice and facts it may have been) and a more westernized approach. The support from the more traditional citizens led to the enactment of laws, not always successfully, to manage “African tradition” by way of the legal system and to cope specifically with the problem of diversity among its people, including both the developed and undeveloped sectors. The Act is such a legal outcome.

This also reflects, inside this “African tradition”, the beginning of a new, post-1994 policy of political correctness, notwithstanding its hypocrisy and detriment to the individual’s constitutional rights. This new policy replaced the old, pre-1994 suppressing policy of the apartheid regime very successfully. This means the continuation of a policy of no tolerance of any criticism by the democratic, post-1994 government on their decisions, legislations, opinions and doings. This lack of opposition includes all the governmental, semi-governmental agencies and non-governmental organizations. It seems to be only the Treatment Action Campaign (TAC) that has not warmed up to traditional healing as a formal medicine partner in the health sector. The DFL (although an initial role-player in the establishment of the Traditional Health Practitioner’s Act), did resist it in a court case, but they focused more on legal protocol.
Up to this point the general view has been that the official opposition in Parliament seems only to be focused on the impact that the Witchcraft Suppression Act (3 of 1957) can have on the constitutional rights of pagans, their religious and cultural beliefs, and the illegal identification of persons as witches and witch-hunting crimes, instead of focussing on the primary negative impact of the Act on public health and discipline.\textsuperscript{60}

7.6 CONCLUSION

The new crippling, dominating and devouring influences of the post-1994 cultural-political setup of South Africa on its existing modern establishments, like healthcare (which the neo-1994 political activists allege purely developed out of colonial and Apartheid regimes and which they see as still sustained by the post-1994 political setup), led thereto that many people in public life are remaining quiet about the traditional healer as a new regulated health service partner. This includes people in healthcare, in academia and journalism, not only because they want to be politically correct, but also to stay out of conflict with or victimization by the present regime. They refrain completely from any criticism or even an opinion on health, religious, cultural, indigenous and political phenomena. A curtain of "silence" has been drawn and the rights of the minority became subdued to that of the majority.\textsuperscript{5,60,62,77-88}

It is therefore no surprise that the Act has become a very dominating pivot, encircled by opportunistic, emotional and political agendas, false cultural distinctiveness and pseudo neo-African (but many times aged and outdated African) intentions. It is projected as the \textit{saviour} of the traditional healer and his indigenous culture and the \textit{solver} of the health problems of South Africa’s poor people.\textsuperscript{5}

Seeing that the Act occupied over 11 years of formal parliamentarian plodding to reach promulgation, but is still not fully operational in 2017, it is doubtful that it has a solid enough legal foundation, empowerment and focus to obtain true statutory status for the traditional health practitioner in future. It is also doubtful if the traditional healer is equipped (in terms of education, training and skills) to be made a successful full member of the health sector.

This doubt is confirmed by the Regulation No 1052 (2015) that aims to give some guidelines as to how the Act can get a seat in the healthcare sector. The wariness since 1994 by the government not to repeal the Witchcraft Suppression Act (3 of 1957, as amended), seems a further indication of doubt regarding the desirability of the traditional healer as a professional health practitioner and possible fear that the traditional healer’s practice can get out of control inside the established healthcare sector and its services.\textsuperscript{6,89}
Two opposing research questions are reflected by this research. *Is the Act a godsend for South Africa? Versus: Is the Act a curse on South Africa’s healthcare?*

From this study it is justified to conclude that the Act spells doom for South African healthcare. The evidence is that it does not have a place in the honourable collection of South African health laws.

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The Act, with the sole aim of recognizing the traditional healer as a statutory health professional within the healthcare establishment, appears to reflect negative manifestations that could do healthcare serious damage.

An in-depth review of official and popular literature on South African traditional healing shows a very one-sided, superficial and unscientific research approach and reporting: one that is based most times on repeated quotations of old, and not always trustworthy, information. Explicit descriptions and analyses, based on sound and in-depth research of historical events and facts, reliable and well-reported statistics and other supportive evidence to enlighten the role of the traditional healer, are completely missing from most literature.

The unfounded claims of traditional healers that they act as a medium with the ancestral spirits; that they are able to interpret messages from the ancestors; that they can bring luck, fidelity, or make rainmaking; that through their distribution of muti around and about the kraal, they can ward off lightening or cause the witch discomfort in her bad endeavours; that they can with muti destroy the powers in other people and can have people contract fatal diseases; are seemingly all accepted by the propagandists and many reporting researchers as true and good personal and practitioner’s talents.

This point of view is maintained, notwithstanding the fact that it is false and in conflict with modern health therapy and treatment. It is also contrary to the Witchcraft Suppression Act (3 of 1957) as amended by Acts No 50 of 1970 and No 33 of 1997 of South Africa to combat the evil behaviour of the traditional healer. Mental impairment, seemingly a major characteristic of the traditional healer, are accepted as normal. They are defined as essential parts of indigenous people’s culture. This view stretches a so-called “African Culture” of South Africa as real and correct to excuse abhorrent behaviour. Even the Act defines the term traditional philosophy with the words “uses of traditional medicines communicated from ancestors to descendants” as a normal part of life and mental phenomenon to be accepted unquestioningly by all South Africans because it is a formal part of the Act.44-50

Even the good name of various South African medical research bodies have been clouded over by the South African traditional healers and their misleading statements about their alleged distinctive role in the manufacturing and sales of so-called “traditional medicines,” or more specifically pre-modern medical products. General information, based on worldwide references, is falsified and used excessively and out of context for the South African scenario.3
The ANC stated again in 1994 in its Health Plan, without offering any sound argumentation or facts, that indigenous cultural preferences, like traditional healing, would become an integral and recognized part of healthcare in South Africa. The basic view is that the consumer must have the right to choose a health practitioner, notwithstanding whether that health practitioner is the best for him or her or society as a whole in terms of training, risk, safety and know-how. To reach this objective, the ANC aimed to change health legislation to facilitate the controlled use of the traditional healer, but at the same time to take total charge of the entire healthcare and its already regulated practitioners in South Africa.¹

Foreign role players in the promotion of traditional healers in South Africa were the AU and the WHO which all emphasized the integration of traditional health into national healthcare in Africa.

A massive infiltration into South Africa’s governmental law-making and executive agencies by traditional healers and their co-agents is also evident. Objection and resistance to the Act were minimal and unimpressive. The main issue for the post-1994 government has been the balancing act between sensitive “African” beliefs and customs, which were widespread among its loyal voters and supporters and a more westernized approach. The support from the more traditional citizens led to the enactment of laws, not always successfully, to manage “African tradition” by way of the legal system and to cope specifically with the problem of diversity among its people, including both the developed and undeveloped sectors. The Act is such a legal outcome.

Seeing that the Act occupied over 11 years of formal parliamentarian plodding to reach promulgation, but is still not fully operational in 2017, it is doubtful that it has a solid enough legal foundation, empowerment and focus to obtain true statutory status for the traditional health practitioner in future. It is also doubtful if the traditional healer is equipped (in terms of education, training and skills) to be made a successful full member of the health sector.

Based on Chapter 7 it is justified to conclude that the Act spells doom for South African healthcare. The evidence is that it does not have a place in the honourable collection of South African health laws and does not contribute positive to the empowerment of the official healthcare sector.

The fifth and last of the five articles is titled: The present and future roles of traditional health practitioners within the formal healthcare sector of South Africa, as guided by the Traditional Health Practitioners Act (22 of 2007). Chapter 8 tests the hypothesis that the Act is empowering the present-day healthcare sector with the statutory recognition of the traditional health practitioner.
CHAPTER 8

THE PRESENT AND FUTURE ROLES OF TRADITIONAL HEALTH PRACTITIONERS WITHIN THE FORMAL HEALTHCARE SECTOR OF SOUTH AFRICA, AS GUIDED BY THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007)

(Article 5)

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ABSTRACT

The promulgation of the Traditional Health Practitioners Act (22 of 2007) was seen as the long awaited start-up of the traditional healing profession in South Africa. The Act was politically driven from the late 1960s onward. Many of these political motivators were based upon outdated cultural ideas, customs and traditions, rooted outside the modern-day healthcare needs and demands of the particular population that traditional healing intends to serve. An in-depth needs and skills analysis to test the viability and sustainability of the South African traditional healers as well as their positions and roles as health practitioners inside the formal healthcare sector, as guided and stipulated by the Act, was lacking in this early development and start-up process. This resulted in the traditional healers' present and future roles as specific healthcare practitioners being both undefined and insufficiently formulated. In addition their existing education, training, skills and abilities to compete in the formal healthcare sector were ignored. Therefore, since the promulgation of the Act in 2007, there was limited professional development for traditional healers, to improve their immediate professionalism and to promote effective role-playing and management in the formal healthcare sector.

The South African traditional healing professional model is still in the foundational stage of its professional development; a stage which the other registered/regulated healthcare practitioners of the country surpassed long ago, making them well-equipped for their role and management as
health professionals in the formal healthcare sector. The whole venture of the statutory recognition of the traditional health practitioners in 2007 as new healthcare professionals with the promulgation of the Act seems to be a failure. There is a definite need to establish how the South African traditional healers are equipped to compete independently in the healthcare sector. If this is not possible, what alternatives are available to steer some of them into the country’s healthcare sector and still make them useful as health practitioners? Coupled to this need is the future status and role of the Act to uphold the roles of traditional healers.

It seems as though the professional position and foundation of the Act is on a level that is meant for the governing of a healthcare group with a well-established learning and management infrastructure. This is an unfortunate situation wherein the incoming traditional healer unfortunately cannot meet the requirements at the moment. Various negative factors have affected the South African traditional healers’ development and position. These include early political out-casting and discrimination from training facilities and work opportunities in the healthcare sector under White rule, while poor organization, strategy and future planning and a lack of self-promotion by traditional healers themselves regarding their positions and roles over the years, seem also to have contributed negatively to the situation. The immediate impact is that this predisposition unfortunately places the traditional health practitioners in situations wherein they cannot always take specific roles at present or in the future as healers in the South African healthcare sector, as intended and guided by the Act. To expect the South African traditional health practitioners to function at present and in future fully within the intentions of the Act, executing certain roles as independent health practitioners in the formal healthcare sector seems to a great extent impossible.

Wherever they are successfully placed in the healthcare sector, their positions and roles seem to be limited. Furthermore, the traditional healers’ places in the formal healthcare sector were already taken by the allied health professions, by such practitioners as homeopaths, naturopaths and ethno-therapists, etc. They are obliged to compete with the established nursing practitioners, psychiatrists and psychologists, as well as medical doctors, all established in clearly defined and functioning roles. These work inclinations and reservations further minimize their roles dramatically in the formal healthcare sector.

Three urgent issues arise when considering the future of the Act and its two outcomes, namely the Traditional Health Practitioners Council as well as the traditional health practitioner. The prominent question is: can the Act continue in its present form or must it be recalled? In its present manifestation the Act and the traditional healers seem to be ineffective and aimless. It is time to consider alternatives to assure the continuation of the traditional healers as practitioners in the
South African healthcare sector. The most obvious and practical one is to accommodate some of the traditional healers, where applicable and possible, in some of the various already established professional Health Councils as healthcare professionals.

**Key Words**

Afterlife, ancestor, customs, gods, healthcare, pre-modern, professionalism, spirits, tradition
8.1 BACKGROUND

The promulgation of the Act was welcomed in 2007 as the ultimate solution to the traditional healers’ insecure and undefined position as healthcare practitioners in the South African formal healthcare sector. Through the implementation of the various resolutions of the Act, it was believed that the newly created health professional, namely the traditional health practitioner, would obtain the necessary recognition to take on various independent roles within the country’s healthcare.\(^{1-18}\)

There seem to be public and political beliefs that the traditional healer is a unique, extraordinary and distinctive type of health practitioner; a special person with secret health training and treatment know-how that he or she inherits or receives from ancestors, spirits and gods. After their graduation as traditional healers, they are seen by some people in South Africa, who believe in traditional healing, as half-man and half-spirit. It is professed that his/her input is of high medical value to the healthcare of the country, especially in the poor areas. This was one of the strong arguments to get the traditional healers statutorily recognized as healthcare professionals, and the Act was promulgated to steer this medical recognition effectively.\(^{1-18}\)

This view of the traditional healers’ abilities is well reflected by the definition of traditional philosophy of the Act, as well as the Act’s described intentions to proclaim traditional healing as a total and unique healthcare fraternity within the established South African healthcare sector.\(^{14-16,19,20}\)

These abilities and skills of the traditional health practitioners would seem to have made them capable to take on positions and to play specific roles as independent health professionals in the present and future formal healthcare sector.

This view is well illustrated in Figure 8.1\(^{21,22}\) in which the central position of the traditional health practitioners favoured by the intentions of the Act and by the specific planning of the government in terms of this Act, are been clearly highlighted (See also Figure 8.2 for comparison).

8.2 AIMS AND OBJECTIVES

The aim of this study was to determine the present and future roles of traditional health practitioners within the formal healthcare sector of South Africa, as stipulated and guided by the Act.
8.3 METHOD

The research was carried out by means of a literature review. This method entails formulating a view based upon the evidence presented in the literature. This approach is used in modern historical research centring upon topics about which there is little information. The databases used were EBSCOHost, Sabinet online and various contemporary sources such as newspapers and reports for the period 2006 to 2016, articles from 1992 to 2016, books for the period 1990 to 2013 and government documents for the period 1974 to 2016. These sources were consulted to offer a view upon the present and future roles of traditional health practitioners within the regulated healthcare sector of South Africa, as guided by the Act.23,24

The findings are offered in narrative form.

8.4 RESULTS

The Act, a legal process to raise the professional identity and status of traditional healers in the South African society, clearly overshadowed the traditional healing leadership thinking on what the traditional healers can and may do versus what they cannot or may not do in practice, in terms of their specific abilities and skills, as well as their public’s needs. This one-sided leadership thinking and belief, together with the traditional healers’ much acclaimed uniqueness to be equipped to take on many and various roles in the formal healthcare sector, left them unprepared for the fact that they had to compete with other healthcare professionals, already established in the formal healthcare sector. To continue old roles and to take on new roles through the implementation of the resolutions of the Act required a new, in-depth understanding of the formal healthcare environment, its various role-players and pre-requisites prescribed in terms of training and practitioners’ rights, etc. The political influence and driving of the traditional healers as a group since the 1960s, especially from 1997 onward in the post-apartheid dispensation advancing Black Empowerment, made them further opportunistic about future roles in terms of promises on their new political and cultural rights in the new South Africa.1-9

The traditional health practitioners had specific roles that they thought they could and would be able to execute with their statutory recognition in 2007. However, these roles were clearly limited, and even blocked for them, as a result of their poor health training and the standards on the one hand which the Act failed to generate. On the other hand, awaiting them were two dominant health groups as strong competitors, well-established in the formal healthcare sector, namely the allied (alternative) and the allopathic fraternities.14-16,19,20
Figure 8.1 confirms that the compilers of the Act and the traditional healers themselves never studied in detail the present-day existence of the allied and the allopathic healthcare fraternities of South Africa, before the Act was initiated in 2003. The allied health group’s in-depth foundation and position in traditional healing in South Africa, established over many years, as an opposition to the new traditional health practitioners created by the Act, was especially bluntly and blindly ignored.\textsuperscript{1-3,5,6,8,27-29}

It is clear that with the acceptance of the Act four years later in 2007, as a legal institution and safe-house for the traditional health practitioners, the government failed completely to acknowledge particularly the unique identities and roles in South African traditional healing of the various established allied health practitioners, such as the homeopaths, naturopaths, phytotherapists and ethno-therapists as similar but opposing healthcare providers to the traditional health practitioners. This ignoring of the traditional healers was also evident in the already established practice education and training-cultures of the allied traditional healthcare and medicine, as specifically represented by the regulated ethno-therapists, phytotherapists, homeopaths and naturopaths. This negative outcome is also unmistakable in the South African post-1994 government’s and some of its leaders’ dislikes for European/Western and pre-1994 health models and systems, as well as their open dissatisfaction and revenge, because the allied health professions had since the 1970s firmly closed their doors for the pre-modern South African traditional healers to be registered with them, even as ethno-medicine practitioners. This door was already closed by the allopathic group on the South African traditional healers in the 1960s.\textsuperscript{1-3,5,6,8,27-29}

\textbf{8.4.1 The allopathic dominance of South African healthcare since 1652}

It is increasingly clear that the education tripartite unity that is an absolute pre-requisite before professional status can be awarded to a healthcare group to be allocated roles or responsibilities, is totally absent from traditional healing in South Africa. Not even the Act and its struggling governing body, the Traditional Health Practitioners Council (THPCSA), could rectify the situation since 2007. This means that a process of empowerment through education and learning, diagnosis and treatment, ending in a scope of practice to take on roles in the formal healthcare sector, has never occurred in South African traditional healthcare.\textsuperscript{30-33}

The medical fraternity, with specific reference to medical doctors and dentists, established itself successfully over the years out of the European traditional medicines and practices, as established in 1652 at the Cape of Good Hope. An initial competitor was certainly indigenous traditional practices and medicines. However, given that this was scattered across the country.
and practiced in a limited manner by certain tribes, and was spiritually orientated, it failed to develop scientifically and to become a role-player in the mainstream of healthcare development. That threat has been erased. Therefore the medical and dental practitioners became the holders and bearers of the holy medical grails in South Africa over the years. World War II gave a new dimension and empowerment to medical development and skills. This well-established fraternity was soon enlarged with various new, well-trained allopathic healers such as physiotherapists and psychologists, as well as the allied healers who took over all the possible traditional healthcare manifestations. This important outcome, which missed the attention of many South African researchers who investigated traditional healing, closed the door forever on the traditional healers for a partnership in present-day formal healthcare; something which the Act has been trying since 2007 to revive at all costs.\textsuperscript{8,16,21,34}

8.4.2 The allied traditional health fraternity’s current statutory recognition in South Africa

The well-established allied traditional health professions of South Africa were ignored by the compilers of the Act. In the 1970s these professions began, with the exception of the traditional healers who had remained passive and undeveloped since 1652, to position themselves strongly in the formal South African healthcare sector in terms of training and education against serious opposition by the apartheid regime and the medical fraternity of that time. In 1982 they obtained ultimate statutory status with the Allied Health Practitioners Act (63 of 1982). Today the allied group consists of 13 disciplines, namely Ayurveda, Chinese medicine, acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy, therapeutic aromatherapy, therapeutic massage therapy, therapeutic reflexology and Unani-Tibb. Chiropractic and Homeopathic training are offered by full-time Masters degrees at the University of Johannesburg (UJ), and the Durban University of Technology (DUT), while Naturopathy and Phytotherapy are offered by the University of the Western Cape (UWC) with three years of training in basic medical sciences and a further two years of specialization in the applicable discipline.\textsuperscript{21,35-39}

8.4.3 Chaotic planning of present and future traditional healthcare

Heretofore the traditional healers had stayed out of any health development since 1652 in South Africa, and when invited, withdrew from participation with the other allied professions in obtaining regulation or to better themselves. They failed, to a certain extent, by their own actions and background, to develop a health science, a learning culture and a professional practice and ethics, as the allied health professions had successfully done. Instead, the traditional healers lingered
on with a spiritual and doubtful practice; one without any real medical or healthcare training or scientific principles and methods.\textsuperscript{1,4,35,36,38-43}

They have remained in disarray since 1652 with the establishment of the Cape of Good Hope Settlement in a pre-modern health training and practice setup. This is well illustrated by the following self-description of a South African traditional healer: “Many traditional medical practitioners are people without education, who have rather received knowledge of medical plants and their effects upon the human body from their forebears.”\textsuperscript{17, par 1}

The result clearly indicates why the traditional healers of South Africa were totally ousted in the 1980s as a partner from the allied health fraternity, basically because of their pre-modern inclinations to medical products, training, diagnosis and treatment, therefore their under par position of not being able to register as allied health practitioners. Despite how much South African politicians and propagandists of traditional healing opposed and discarded this outcome, the fact is that the traditional healers’ positions, roles, training and identification as health practitioners were overtaken in time in South Africa by the allied traditional healers, specifically the homeopaths, naturopaths and phytotherapists. This gradual incorporation became official and final in terms of the Allied Health Professions Act (63 of 1982).\textsuperscript{17,34}

This phasing out of traditional healing, a remnant of the old tribal culture of South Africa is a reality which propagandists and believers of traditional healing do not fully understand or want to admit today. Here in South Africa the thinking and belief on healthcare models for indigenous people of these propagandists and believers, strongly supported by opportunistic politicians, are still naively anchored in the anthropology and philanthropic thinking on African cultural lifestyles of the past. The need for their service is also distorted in the process as essential. Through this pathway these propagandists and believers are trying to recreate a domain for the traditional healers in the formal healthcare sector of South Africa, notwithstanding the strong opposing healthcare inclinations and intentions of the Act to their outdated thinking as well as the assimilation of traditional healing into the professions of homeopathy, naturopathy and phytotherapy, as activated by the Allied Health Professions Act (63 of 1982).\textsuperscript{1-22}

The chaotic planning on traditional healthcare in South Africa is undoubtedly further aggravated by the outdated opinions, viewpoints and influences of outsiders who are not only unfamiliar with the South African healthcare scenario, but are opposing formal healthcare education, training and standards for the traditional healers, seemingly in an exclusive effort to revive colonial thinking on “good” healthcare delivery and services upon behalf of indigenous people. This stereotypical and subjective thinking blindly ignores the modernization and upliftment of the living standards,
accompanied by enormous changes in personal, economic, social and especially healthcare needs and preferences of the greater South African population since the 1990s, which has in practice nullified the need for pre-modern traditional healing.\textsuperscript{1-22}

The present-day chaos in planning of the South African traditional healing must be addressed urgently. There are first level remedies available.

8.4.4 There may still be time to place some traditional healers within the established statutory health professions

The traditional healer’s position as an independent health practitioner in terms of the Act seems to increasingly be unacceptable in terms of various healthcare criteria, nor viable or sustainable in South Africa as an independent healthcare profession. On the other hand, there is at present still a possible place for some of the traditional healers such as the herbalists group within the allied health group, as well as for some of the other traditional healers such as diviners and birth attendants in the other health groups. As a result of their diversity in training, education, practice styles and healthcare beliefs it is impossible to categorize them into a single, uniform group to be considered for assimilation into the established healthcare groups. Selection can clearly only be carried out on the principle that individuals may be incorporated into these established health groups. This, on the other hand, can only happen if the traditional healers fulfil a minimum level of formal education and training, to enable them to be trained on a tertiary and professional level within these various groups’ professional requirements and to reflect the skills and abilities for patient safety services.

Traditional healers as individuals must be redirected immediately. As a point of departure it must be considered to repeal the Act and to phase out the Interim Traditional Health Practitioners Council as a governing body (See Figure 8.2). The fact that both, although introduced in 2007 to professionalize and progress traditional healing, are today still in a passive gear of performance and the formal registration of the traditional health practitioners is still under par, makes such an intervention at this stage both possible and easy. The failure of the traditional health practitioners, notwithstanding the Act, is legal driving of the process and the direct political support from government bodies, to move successfully since 2007 into the formal healthcare sector of South Africa, to take on specific roles independently from the other healthcare professions, to mobilize an expected group of clients to be viable and sustainable as a specific healthcare practitioner and to create a formal learning and training culture, puts the continuation of the traditional health practitioners as a present and future role-player in the healthcare sector in jeopardy.\textsuperscript{8,21,22,34,39,44-50}
With reference to the unregulated alleged 200 000 and more traditional healers as a group, most of them must be left unregulated as in the past. In this respect it must be noted that from strict criteria used, it seems that not more than 4 400 of these traditional healers qualified in some way to be become registered in terms of the Act. This means that if a strict selection is being made between charlatans, bogus, bona fide and “real” traditional healers in South Africa, very few of the alleged 200 000 traditional healers will reach the end-mark to be registered in terms of Act. It is these potential candidates that must be considered for possible registration with the already established healthcare councils. 8,21,22,34,39,44-50

Individuals from this selective group of traditional healers such as herbalists can be moved into the homeopathy, ethno-medicine, naturopathy or phytotherapy disciplines of the Allied Health Practitioners Council. Individuals from the diviners can be moved into three possible areas, namely as psycho-counsellors to the Health Professions Council, as social counsellors to the Council for Social Welfare Sciences and some can be homed with old African church groups as priests or spiritual caregivers. Individuals from the grouping of birth attendants can be moved into the Nursing Council as assistant midwives. It seems that only the traditional surgeon may be problematic to accommodate into the established healthcare councils, basically due to their history of risks to healthcare.

With the above approach, the Act, the Traditional Health Practitioners Council (THPCSA) as well as the traditional health practitioners will automatically lose their central position and disappear from the South African formal healthcare scene if the Act is not swiftly repealed.

The aforementioned suggestions are reflected in Figure 8.2,21,22

**8.5 DISCUSSION**

The traditional healers were at some point in the past part of the allied fraternity, but lost their healthcare standing in the greater South African healthcare context due to their pre-modern and unprofessional training and practices. Their passivity to develop was also a negative determinant. Real traditional healing and traditional medicine, such as ethno-medicine and phyto-medicine, are now fully part of the regulated homeopaths, naturopaths and phytotherapists’ practices and medicine.8,21

The South African traditional health practitioners, with their African cultural uniqueness, enforced by the Act, have clearly been driven by its political intentions under a cultural mask since 2007. Their idolization as a unique healthcare practitioner was a further driver. They are uninvited partners in the modern-day healthcare sector of South Africa. They find themselves for good
reason in a health care "no-man’s land," as a direct result of the inapplicability of the Act upon the healthcare environment. In addition the phasing out of the traditional healers’ entity and identity as healthcare practitioners, by their own actions as well as external influences over many years, further exacerbated the situation. At present they are not only overstepping the practice rights of the current existing regulated health practitioners of real traditional medicine, but are, as health practitioners, within the established healthcare sector, not professional or financially viable or sustainable in this present identity. Furthermore there are life risks for the public with their pre-modern products and treatment.

8.6 CONCLUSION

The Act is not healthcare friendly to the broad public, nor friendly to the traditional health practitioners that it created. The odds are against the traditional health practitioners, as evidenced by their history and their inadequate healthcare training, skills and abilities, to secure and uphold specific roles in the present and future formal healthcare sector of South Africa within the legal confines of the Act.

The truth is that the traditional health practitioners cannot be re-introduced as independent healthcare practitioners in the present and future formal health sector of South Africa. In their present form they are “Rip van Winkel”, 300 years too late for any role.

Alternatives, completely removed from the Act and its governing body, the Traditional Health Practitioners Council (THPCSA), must urgently be found to accommodate skilled and able traditional healers in the present and future formal healthcare sector of South Africa. Direct assimilation into the various established and functioning healthcare governing-bodies seems to be the most obvious. This option must be considered.

Good decisions are sometimes hard to take, but are worthwhile in the end.
REFERENCES


Figure 8-1: The present-day regulation of healthcare practitioners in South Africa (adapted from Caldis\textsuperscript{21}, p. 2; Gqaleni et al.\textsuperscript{22}, p. 177)
Figure 8-2: Corrected future regulation of healthcare practitioners in South Africa

Derived: Caldis, 21 p. 2; Gqaleni et al., 22 p. 177
DESCRIPTION OF INFORMATION TRANSFERRED
FROM CHAPTER 8 TO CHAPTER 9

The promulgation of the Act was seen as the long awaited start-up of the traditional healing profession in South Africa. The Act was ‘politically driven from the late 1960s onwards. Many of the political motivations were based on outdated cultural ideas, customs and traditions, rooted outside the modern healthcare needs and demands of the particular population that traditional healing intends to serve. There was no in-depth needs and skills analysis to test the viability and sustainability of the South African traditional healers and their positions and roles as health practitioners inside the formal healthcare sector, as guided and stipulated by the Act, in this early process. This resulted in the traditional healers’ present and future roles as specific healthcare practitioners being both undefined and insufficiently formulated. In addition, their existing education, training, skills and abilities to compete in the formal healthcare sector received no attention. Therefore, since the promulgation of the Act in 2007, there has been limited professional development for traditional healers to improve their immediate professionalism and to promote effective role-playing and management in the formal healthcare sector.

Chapter 8 shows that the South African traditional healing professional model is still in its infancy; a stage that the other registered/regulated healthcare practitioners of the country have surpassed long ago. They are already equipped for their roles as health professionals in the formal healthcare sector. The whole venture of the statutory recognition of the traditional health practitioners in 2007 as new healthcare professionals with the promulgation of the Act seems to be a failure. There is thus a definite need to establish how the South African traditional healers are equipped to compete independently in the healthcare sector. If this is not possible, what alternatives are available to steer some of them into the country’s healthcare sector and still make them useful as health practitioners. Coupled with this need is the future status and role of the Act in upholding the roles of traditional healers.

Chapter 8 shows that the Act is shaped in a manner that befits the governing of a healthcare group with a well-established learning and management infrastructure. This is an unfortunate situation, as traditional healers cannot yet meet the requirements at the moment. Various negative factors have affected the South African traditional healers’ development and position. It is unreasonable to expect of traditional health practitioners to function within the delimitations of the Act and to execute certain roles as independent health practitioners in the formal healthcare sector.
Wherever they are successfully placed in the healthcare sector, their positions and roles seem to be limited. Furthermore, the traditional healers’ place in the formal healthcare sector has already been taken by the allied health professions such as homeopaths, naturopaths and ethno-therapists, etc. They are obliged to compete with the already established nursing practitioners, psychiatrists and psychologists, as well as medical doctors, all established in clearly defined and functioning roles. These work inclinations and reservations further minimize their roles dramatically in the formal healthcare sector.

The idea of practicing South African traditional health practitioners and their so-called African cultural uniqueness enforced by the Act, is clearly driven by political intentions under a cultural mask since 2007. Their idolization as a unique healthcare practitioner was a further driver. They are uninvited partners in the modern healthcare sector of South Africa. They find themselves in a healthcare “no-man’s land,” for good reason, as a direct result of the inapplicability of the Act to the healthcare environment. The phasing out of the traditional healers’ as healthcare practitioners by their own actions as well as external influences over many years, further exacerbated the situation. At present they are not only overstepping the practice rights of the current regulated health practitioners of real traditional medicine, but are, as health practitioners within the established healthcare sector, not professional or financially viable or sustainable in this present form. Furthermore, there are life risks for the public with their pre-modern products and treatment.

It is clear from Chapter 8 that the odds are against the traditional health practitioners, as evidenced by their history and their inadequate healthcare training, skills and abilities. They cannot at this time play specific roles in formal healthcare sector of South Africa within the legal delineations of the Act. The truth is that the traditional health practitioners cannot be re-introduced as independent healthcare practitioners in the formal health sector of South Africa. They do not contribute positively to the development of the official healthcare sector. Chapter 8 confirms also the findings of Chapter 4 to 7, namely that the Act and traditional healers themselves do not contribute to the South African healthcare sector.

Chapter 9, the final chapter, titled: Summary, conclusions and recommendations, reflects the research findings of Chapters 2 to 8, with the main focus on the Chapters 4 to 8. The findings of Chapters 2 to 3 serve only as informative and supportive information to the execution of Chapter 1’s experimental design and research description to can evaluate experimentally the findings of Chapters 4 to 8 on the statutory impact of the Act and the traditional health practitioner on the South African healthcare sector.
9.1 SUMMARY

This study scrutinized the impact and implications of the Act, the role of traditional healers as professional healthcare providers and the traditional health fraternity as a specific healthcare group within the present South African healthcare establishment. These role-players’ possible future impact on and implications for the South African healthcare establishment were researched and considered.

In this regard the following six objectives for this study were formulated:

9.1.1 Objectives

The objectives divide into five special objectives that are overarched by one general objective.

9.1.1.1 Specific objectives

There are five specific objectives:

RO1: to determine if the traditional healer has a modern medical identity in South Africa;

RO2: to determine if the Traditional Health Practitioners Act (22 of 2007) is in conflict with the Witchcraft Suppression Act (3 of 1957).

RO3: to determine if the Act is a mistake in terms of the South African Constitution.

RO4: to determine if the Act is a godsend or an act that spells doom for South Africa’s healthcare.

RO5: to determine if the traditional healers have a role within the formal healthcare of South Africa as guided by the Act.

9.1.1.2 General objective

There is one general objective:

RGO: to determine if the Act and the South African traditional healers can contribute to the South African healthcare system.
9.1.2 Hypotheses

The following six hypotheses versus five alternative hypotheses were examined in correspondence with the above six objectives:

9.1.2.1 Specific hypotheses

There are five specific hypotheses:

**H1:** The traditional healer does have a modern medical identity in South Africa.

**H2:** The Traditional Health Practitioners Act (22 of 2007) is not in conflict with the Witchcraft Suppression Act (3 of 1957).

**H3:** The Act is not a mistake when viewed in light of the South African Constitution.

**H4:** The Act is a godsend for South Africa’s healthcare.

**H5:** The traditional healers do have a role within the formal healthcare of South Africa as guided by the Act.

9.1.2.2 General hypothesis

There is one general hypothesis:

**HG:** The Act and the South African traditional healers contribute to the South African healthcare system.

9.1.3 Lay-out and review of chapters

9.1.3.1 Lay-out of chapters

The lay-out of the thesis was as follows:

Chapter 1 provided the problem statement, objectives and the hypotheses of the study.

Chapter 2 provided a political-historical literature review of the promulgation of the Act and the statutory recognition of traditional healers as healthcare professionals (see Articles 6 to 11).

Chapter 3 described the resolutions, implementations and implications of the Act (see Articles 12 to 19).
Chapters 4 to 8 (see Articles 1 to 5) dealt with the five research objectives of the study.

Chapter 9 provides the summary, conclusions and recommendations of the research.

9.1.3.2 Review of chapters

The contents of the nine chapters are as follows:

Chapter 1: Experimental design and research description, including problem statement, objectives and hypotheses

This chapter consists of the experimental approach of the study, the problem statement, objectives, hypothesis, method and procedure, and the thesis structure.

Chapter 2: Political-historical literature review of the promulgation of the Act and the statutory recognition of traditional health practitioners in South Africa

This chapter reflects on the available literature on the political-historical background to the process of the promulgation of the Act and the statutory recognition of traditional healers in South Africa.

Chapter 3: Resolutions, implementations and implications of the Act

Chapter 3 describes the resolutions, implementations and implications of the Act and the recognition of traditional healers. The possible future impact of the Act on the healthcare sector comes under focus.

Chapter 4 (Article 1): Does the traditional healer have a modern medical identity in South Africa?

This chapter tests the assumption that the traditional healer is a medical healer. It is clear that the traditional healers were wrongly described by early missionaries and colonists as medical entities while they were actually spiritual healers. They are remnants from a previous, pre-modern time of living in South Africa. The current re-moulding is a result of the political intentions of politicians with outdated cultural, political and religious thoughts. The traditional healer’s assumed exclusive medical distinctiveness is non-existing in modern-day South Africa. The Act’s intention is clearly inapplicable and inappropriate to accommodate and to regulate an outdated type of a pre-modern priest as a health professional inside the formal health establishment. This kind of registration
belongs exclusively to churches. The impact of the traditional healer as a medical entity can be disastrous for the healthcare sector of South Africa.

Chapter 5 (Article 2): Is the Traditional Health Practitioners Act (22 of 2007) in conflict with the Witchcraft Suppression Act (3 of 1957)?

The research of this chapter confirms that the Act was promulgated without a thorough understanding of the offences described in the Witchcraft Suppression Act (3 of 1957). The Witchcraft Suppression Act (3 of 1957) basically renders the Traditional Health Practitioners Act (22 of 2007) null and void. The Witchcraft Suppression Act (3 of 1957) is of cardinal importance to counteract the dangers of the traditional healer’s practice processes. It is an important criminal law and Constitution-friendly. The Traditional Health Practitioners Act (22 of 2007) is an improper healthcare law that legalized witchcraft and the supernatural and offers opportunities to criminal behaviour. The Witchcraft Suppression Act (3 of 1957) highlights further shortcomings of the Traditional Health Practitioners Act (22 of 2007) and of the doubtful status of the traditional healer as a law-abiding health practitioner. Some of their practice activities, like the belief in the supernatural, future-telling and occult science, etc. are illicit in terms of the Witchcraft Suppression Act (3 of 1957).

Chapter 6 (Article 3): The Traditional Health Practitioners Act (22 of 2007): A mistake in view of the South African Constitution?

This chapter clearly reflects that the Act was promulgated without an applicable and appropriate scientific needs analysis. The Act is to an extent in conflict with the Constitution and the Witchcraft Suppression Act (3 of 1957). The fact that the Act is still not active nearly a decade after its promulgation, confirms that it did not pass the test of good legislation even today. The Act is one of many inapplicable, inappropriate and unworkable Acts that have passed through Parliament since 1994. It is an improper healthcare act and a constitutional mishap, but stands strong with the political sanctioning it carries. It will not easily be revised, nor be repealed in the next 10 to 20 years. Indeed, more and stronger official sanction can be expected, making its devastating impact on future healthcare uncountable.

Chapter 7 (Article 4): The Traditional Health Practitioners Act (22 of 2007): A godsend or a curse for South Africa’s healthcare?

This chapter evaluates the impact of the Act on the South African healthcare setup and patient rights. South Africa’s healthcare system is supported by excellent laws regulating its healthcare systems and practitioners, but this Act is different. The Act, with its sole aim to recognize the
traditional healer and to make him a full member of the formal healthcare establishment, fails the pre-requisites needed to be part of it. It can have the potential to do serious damage to the healthcare establishment. The Act started with controversy in 2003 and it is still seen as exclusive political-health legislation to benefit an outdated, pre-modern priest. It will undoubtedly bring serious problems for the South African healthcare establishment and its regulated health professionals. It is a curse.

Chapter 8 (Article 5): The present and future roles of traditional healers within the formal healthcare of South Africa, as guided by the Traditional Health Practitioners Act (22 of 2007).

This chapter shows that the traditional healer is clearly an uninvited partner in the modern-day health sector of South Africa. First, it is important to know that they had phase themselves out of healthcare long ago as result of their pre-modern and unprofessional training and health practices. Second, the Act failed to create a new position in the healthcare sector for the traditional healer since 2007. The traditional healer is clearly overstepping the practice domains and rights of the regulated healthcare professionals through his enforcing into the healthcare establishment by the Act. He cannot be re-introduced as a healthcare professional into the present health sector; there is not any open place left in this sector for a dysfunctional practitioner after 300 years.

9.1.4 A Perspective on Above Research Findings

The Act itself is a first-world health legislation that puts South African traditional healers into a very invidious dilemma: on the one hand there is the benefits and practice rights that it bestows on him but which he cannot execute; on the other hand it unintentionally splays out his shortcomings in training, expertise and knowledge, together with his inferior position as a health practitioner.\(^5\)

The Act offers uncontested statutory status to the South African traditional healers, equal to that of the regulated health professions, if not more in certain practice spheres. It makes the traditional healers, under the guardianship of the DOH, a full status healthcare provider in all the health establishments of South Africa. It also offers the traditional healing fraternity the opportunity to train legally a new generation of traditional healers, together with the establishment (or obtaining) of training institutions and the development of traditional healthcare programs and qualifications. An opportunity is also offered to an assumed 200 000 unregistered traditional healers, without any formal or recognized health or medical training or even school education, to obtain unconditionally statutory status as health and medical professionals.\(^5\)
The implementation of the Act will be very complicated, far more than the fathers of traditional healing realize, and negative outcomes which they are really not in a position to address or to manage.

First, to train a new generation of traditional healers will take at least 10 to 15 years; and the establishment of formal training institutions and the development of programmes are expensive and time-consuming. The immediate statutory recognition of an assumed 200,000 (or more) traditional healers, waiting urgently since 1994 for registration, is problematic. The process to register these alleged 200,000 will take much time and money, seeing these healers’ dissimilar trainings, abilities, experiences, together with their own personal underdevelopments. In this reference it must be remembered that the most traditional healers are illiterate, living in isolated rural areas, is not computer-educated, and in some cases, can only speak a single indigenous language. Poverty in their working areas and their own life can play a role in blocking registration and their further development. Further are the concepts to be registered and to respect professional ethics an unknown life- and professional experience for many of them. The unconditional acceptance and registration of the 200,000 assumed healers on the register, just because it is believed to be their democratic and political rights as well as the realizing of promises made by politicians since 1994, spells chaos.5,6

Second, the Act was forced to fit a group of pre-modern, third world spiritual caregivers or priests and it is clearly not working. To move into a first-world health sector any unregulated and under par educated group, like the traditional healers in this case, can be traumatic and full of conflict for them as well as the public whom they are going to serve.

Third, the Act is sadly political motivated, constructed with very little cognitive considering, business, strategy and project planning. It was officially started in 1969 by the ANC’s blue print of a supposed new democratic health system for South Africa: one in which it is falsely professed that the traditional healer, as a cultural remnant of “old” Africa, must take a prominent role. The Act is part of a well-planned, masked attack on the European/Western lifestyle that the propagandists of South African traditional healing alleged still exist and overrate in present-day life in South Africa. Traditional health and its practitioners are projected with false arguments as a good traditional health culture that was suppressed by the European/Western governments over many years and therefore could not develop into a real healthcare science. The same hostility is shown with the Act to the present-day modern health sector, which is seen as exclusive Western/European, by disempowering it on many areas, especially with the enforcing of the traditional healer into the health system.5,7-21
Fourth, in linking to above, the Act is further a direct outcome of the government’s 1994 plan of reform and transformation to activate a multi-faced, multicultural and multi-cosmologically South African healthcare system, with the focus on empowering the community and the community health worker, of which the traditional healer is one. The main aim, well masked it seems, was disarming the South African medical doctor in terms of his established rights and influences.

An important outcome of the Act, although surely unintentionally and not truly part of the South African traditional healing setup, is its revelation of a long time lingering conflict inside the regulated health professions themselves. The prohibition of psychologists, pharmacists and nurses from independently prescribing medicines while awarding this right to the traditional healer, can cause conflict. The Act intentionally goes much further: it challenges the exclusive rights and privileges of the other five health acts in their strive to be the only health mandated legislations with unique health practitioners, and it dares the broad public, the organized healthcare sector and the regulated healthcare professionals to show the Act and traditional health practitioner as wrongs and to stop them. If these dares by the traditional healers are not opposed with constructive opposition, nothing is going to neutralize the negative impact of the Act and the traditional health practitioners on the empowerment of the South African healthcare sector. This was exactly what this research did.

9.2 CONCLUSIONS

The conclusions that are drawn from this research are presented in accordance with the six objectives and the six hypotheses as postulated in Chapter 3.

The medically untrained, uneducated and pre-modern traditional healer (also described as traditional doctor, doctor, traditional health practitioner or medicine man and many other medical practitioner names) is medically unqualified, offering a bogus and harmful health service. He is not even accepted as a priest anymore, and is seen as a pre-modern phenomenon, also with no significant cultural and economic distinctiveness in South Africa. He misleads, thankfully, only a very small group of lower-educated and poor South Africans, who, as result of poor and negative living conditions and environments, still believe in the supernatural and witchcraft, and, as a result use the traditional healer. They are exploited due to their own ignorance. It is understandable why the Mozambican government, after independence in 1975, wanted to force the traditional healer out of its health system and re-educate them. They had very good reason for that.5,21,22

The medically untrained, uneducated and pre-modern traditional healer is a medical, religious, cultural and economic remnant and outcast from the pre-1900s, ignored today by all the formal
and semi-formal recognized occupation-classifications worldwide. The *International Standard Classification of Occupations* does not refer to them at all. Their South African official occupation listing of critical skills shows that of the 200 occupations in need, the traditional health practitioner is not one, nor is he even referred to. They could also not obtain any type of listing on presumed skills levels. Hereto, the regulated medical doctor, medical specialist, nurse and pharmacist are still all classified as critical skills needed. This ignoring of the traditional healers as a needed profession is basically because of their poor training status and know-how and therefore as a lack “in need of.”

The true fact is that witchcraft, wizardry, sorcery, bad magic, quackery and criminality are all parts of the practice of the traditional healer’s practice, irrespective if he is a “good” healer. Sadly, he is now part of the South African health system through the Act. The South African traditional healer is a liability to the country. It was side-lined long ago because of its risks to the health of the homo Modernist-Black and was successfully replaced by modern healthcare models and systems by their own decision. It is one in which the African traditional medical mixtures and products, the traditional healer and the Act cannot and do not play a role or are needed anymore. “African traditional medicine” is pre-modern and a health antiquity that belongs to the cultural paraphernalia of a museum.

Various researchers, propagandists and activists emphasize the need to regulate traditional healers and their health products under the pretence of protecting the health and life of their customers. But instead of limiting the dangers by ruling it out of the South African life, the traditional health fraternity is now given an absolute free hand to practice with the Act. In the first place, traditional healing should not be accepted, recognized and regulated as done since 1994; it should have been phased out long ago from the South African health life by better medical and health care services and the upkeep of the anti-witchcraft legislations. Instead, by sidestepping its duties and failure to deliver better essential formal health services themselves since 1994, the present South African government put the Act in place. One wrong was tried to be corrected by a bigger wrong.

The fact that the HPCSA, AHPCSA and the Councils for Nursing and Pharmacy miserably failed to criticize and to oppose the Act in public as well as to take direct legal steps to safeguard their registered practitioners’ rights against it, makes the present-day situation more forcing to rectify.

The post-1994 government of South Africa’s own doubt in the desirability and wisdom of the traditional healer as a regulated health practitioner in the South African health sector is reflected by the delay with implementation with nearly 14 years since 2003 with the introduction of the
Traditional Health Practitioners Bill and the upkeep of the Witchcraft Suppression Act (3 of 1957) on the South African list of acts.\textsuperscript{5,19}

Therefore, to say, as the government and propagandists of traditional healing do, namely that the promulgation of the Act’s main intention was to restore only the dignity and value of the “African culture and tradition” as it was before 1900, is absurd and illegitimate. No evidence confirms that the traditional healer was in the past a culture and a tradition of substantial size.\textsuperscript{29}

The Act is not enough legally founded, empowered and focused to obtain real statutory status for the traditional health practitioner and to make it successfully a full member of the health sector. Neither is the traditional healer himself trained, educated or scientific established to be a skilled and responsible health practitioner and therefore to embrace successfully the Act.\textsuperscript{5}

It seems that an urgent and immediate intervention and interference of the Act is needed, seeing that it can take up to 20 years and more to get a sympathetic new government in Parliament or when the legal situation is favourable to take on the Act. In that time the healthcare sector, and the medical fraternity specific may irreparably been ruined.

\textbf{9.2.1 Hypotheses Testing and Confirmation}

\textbf{9.2.1.1 Specific Hypotheses}

Five specific hypotheses must be tested and confirmed:

\textbf{H1:} The traditional healer does have a modern medical identity in South Africa:

- The sole role-player who has to take on and master the delivering of a professional traditional health service to the public is the statutorily recognized \textit{traditional health practitioner}. However, thus far, the precise health practice offered, training and the practitioner’s role as a healer in the society, have not been clearly defined. The various definitions and descriptions in the literature of the identity of the traditional healer are contradictory, making the formulation of a single definition and meaning impossible. The Act’s regulations, as embedded in its 52 Sections, create a legal framework of definitions. One specific definition outlines what is meant by the \textit{traditional health practitioner}. This definition includes four sub-types of healers, namely the diviner, herbalist, traditional birth attendant and traditional surgeon. Various other names for and types of traditional healers seem to exist outside the Act’s statutory definitions. It also seems as if the practice scopes, training and methods of diagnosis and treatments of these different healers are not uniform. The legal definition of a traditional health practitioner, as
offered by the Act, is vague and insufficiently formulated. This shortcoming frustrates the
intention of the Act to make the traditional health practitioner the exclusive role-player who
has to deliver a traditional health service to the public. Indeed, the traditional fraternity and the
compilers of the Act failed to offer a single acceptable definition or description of who the
traditional health practitioner is. It is also clear that the practice, diagnosis and treatment styles
and approaches of the various traditional healers cannot be embedded in a single identity as
the Act had tried to do with the definition of the traditional health practitioner. The inclusion of
the traditional health practitioner in the country’s formal health establishment and its
acceptance by the established medical fraternity as a profession in healthcare are at this stage
clearly impossible. Sound legal formulations and definitions of the various types of healers
are needed before the Act definitions on the traditional health practitioner and its sub-types
can be accepted as legal and as applicable to all traditional healers for registration. At the
moment the definition traditional health practitioner fails the test to pass as a uniform
professional and legal identity acceptable and useful for all the tribes or ethnic communities
in South Africa (For detail description sees Chapter 4: Article 1). # Hypothesis H1 is therefore
rejected.

H2: The Traditional Health Practitioners Act (22 of 2007) is not in conflict with the Witchcraft
Suppression Act (3 of 1957) in present-day South Africa:

- The Act with main aim to regulate the traditional health fraternity was immense driven since
the 1960s by political activists and traditional healing propagandists and became a reality after
the 1994 political dispensation. Certain definitions of the Act seemed to be very controversial;
especially the role of the supernatural in healing that could be associated with witchcraft and
criminal related behaviour. From the data extracted from various sources it seems as if the
Act was promulgated without an in-depth research on the role that the traditional healer can
play in witchcraft activities. The aim of the Witchcraft Suppression Act (3 of 1957) was totally
ignored. The Witchcraft Suppression Act (3 of 1957) is not discriminative against the practice-
behaviour of the traditional healer or the regulations of the Traditional Health Practitioners Act
(22 of 2007) which determine the professional status of traditional healing in South Africa. To
the contrary, the Witchcraft Suppression Act (3 of 1957) is very accommodating of the
misbehaviour and malpractice of the traditional healer. Hereto some of the Traditional Health
Practitioners Act (22 of 2007)'s regulations seem to stand in conflict with certain of the
regulations of the Witchcraft Suppression Act (3 of 1957), while the traditional healer’s practice
activities seem also to violate extensively some of the regulations of the Witchcraft
Suppression Act (3 of 1957), which determines criminal behaviour. The Traditional Health
Practitioners Act (22 of 2007) is an improper Act, an unacceptable reality in modern-day South Africa and must be repealed and not the Witchcraft Suppression Act No 3 (1957) (for detail description sees Chapter 5: Article 2). # Hypothesis H2 is therefore rejected.

**H3:** The Traditional Health Practitioners Act (22 of 2007) is not a South African Constitutional mishap:

- The Act went untested through the legislature, driven inside the post-1994 socio-political dispensation. The Act was promulgated without an applicable and appropriate scientific needs-analysis. The Act seems to stand to a great extent in conflict with the Constitution as well as various other Acts, like the Witchcraft Suppression Act (3 of 1957). The Act was shaped by two strategy manifestos of the ANC, namely the Manifesto of the NDR of 1969 and the NHP of 1994. Never was there over the years deviated an inch from these master-plans in the execution of political and cultural preferences, notwithstanding sound logical, legal and financial argumentation against it. This fixed viewpoint malformed thinking and doings around the true rights of individuals and groups, democracy and the correct interpretation of the various clauses of the Constitution. It is a constitutional mistake. It is clear that the South African traditional healers, notwithstanding their new statutory status as traditional health practitioners and the backing of the Act failed the test to become professional healthcare practitioners, to obtain an established healthcare system, to affirm independence with unique training, ethics, practice domains and a sound medical science inside the legal framework on healthcare. They are basically professional impotent. At the moment (indeed since 1652 and pertinent since 2007) they failed totally to take on even basic challenges, like to organize themselves as a group or to develop a traditional healthcare culture and to master the legal guidelines of the Act and other South African laws like the Constitution. The taking on of complicated professional and legal challenges and dilemmas is just not part of their present-day abilities. The Act shows how the lawmakers and the traditional healing leadership failed to make an in-depth study of the traditional healing culture and to reconcile the Act's intentions and implications with present-day realities (For detail description sees Chapter 6: Article 3). # Hypothesis H3 must be rejected.

**H4:** The Traditional Health Practitioners Act (22 of 2007) is a godsend for South Africa's healthcare:

- South Africa's healthcare system is supported by excellent laws that regulate its healthcare practitioners. These laws assure that the health practices, ethics and training of its practitioners are world class, and that the future development of the healthcare establishment
and its services will at all times benefit South Africans. The Act, with the sole aim of recognizing the traditional healer as a statutory health professional within the healthcare establishment, reflects negative manifestations that could do healthcare serious damage. The Act is been seen as a pre-modern health legislation for a modern society. Furthermore, it was not well researched in respect of the need for traditional health, the negative effect that it could have on general healthcare or established health professions and other long-term consequences. Neither was its level and standards of training ever properly debated. It is doubted if the Act has a solid enough legal foundation, empowerment and focus to bring good healthcare to the population or to change the traditional healer into a skilled and able healthcare practitioner, assuring healthcare of excellence to the population. It is also doubtful if the traditional healer is equipped (in terms of education, training and skills) to be made a successful full member of the health sector. From this study it is justified to conclude that the Act spells doom for South African healthcare. The evidence is that it does not have a place in the honourable collection of South African health laws. The Act is an act that spells doom for South Africa’s healthcare (For a detail description sees Chapter 7: Article 4). # Hypothesis H4 must be rejected:

**H5:** The traditional healers do have present and future roles within the formal healthcare of South Africa as guided by the Act:

- It was inapplicable and unwise to recognize the South African traditional healer as a regulated health professional with the Act and to force down a legal view of the traditional healer as an equal to the medical doctor in South Africa. Since the promulgation of the Act in 2007, there has been limited professional development for traditional healers to improve their immediate professionalism and therefore to promote effective role-playing and management in the formal healthcare sector. The South African traditional healing professional model is still in the foundational stage of its professional development. The immediate impact is that this predisposition unfortunately places the traditional health practitioners in situations wherein they cannot always take specific roles at present or in the future as healers in the South African healthcare sector, as intended and guided by the Act. To expect the South African traditional health practitioners to function at present and in future fully within the intentions of the Act, executing certain roles as independent health practitioners in the formal healthcare sector seems to a great extent impossible. Wherever they are successfully placed in the healthcare sector, their positions and roles seem to be limited. The whole venture of the statutory recognition of the traditional health practitioners in 2007 as new healthcare professionals with the promulgation of the Act seems to be a failure. Furthermore, the
traditional healers’ places in the formal healthcare sector were already taken by the allied
health professions, by such practitioners as homeopaths, naturopaths and ethno-therapists,
etc. Therefore they are obliged to compete with the already established nursing practitioners,
psychiatrists and psychologists, as well as medical doctors, all established in clearly defined
and functioning roles. These work inclinations and reservations further minimize their roles
dramatically in the formal healthcare sector. In its present manifestation the Act and the
traditional healers seem to be ineffective and aimless. The future of the Act lay in one
outcome, namely that the Traditional Health Practitioners Council as well as the traditional
health practitioner must be recalled and that some traditional healers, where applicable and
possible, accommodated in some of the various already established professional Health
Councils as healthcare professionals. The Act is not healthcare friendly to the broad public,
nor friendly to the traditional health practitioners that it created. The truth is that the traditional
health practitioners cannot be re-introduced as independent healthcare practitioners in the
present and future formal health sector of South Africa. In their present form they are 300
years too late for any roles (For detail description sees Chapter 8: Article 5). # Hypothesis H5
is therefore rejected.

9.2.1.2 General hypothesis

One single general hypothesis must be tested and confirmed:

HG: The Act and the South African traditional healers’ impact are empowering the present and
future South African Healthcare System:

• The Act failed in general to position South African traditional healers statutory as prominent
healthcare practitioners in the healthcare sector. The traditional healing fraternity per se also
failed to promote the education and training, as well as the professional integrity of South
African traditional healers since 2007 within their new founded statutory status as a healthcare
practitioner. Further are there various challenges and dilemmas awaiting the Act that it is legal
and professionally not equipped to overcome in the immediate future. As reflected by its more
recent history since 2007, the South African traditional healing fraternity stayed impotent, as
since 1652, and failed to accept new challenges, the management and driving of its own
future, lacking planning, strategically thinking. They failed to offer any trustworthy evidence,
besides political and superficial rhetoric, why traditional healers must be accepted as skilled
and able healthcare professionals in the formal healthcare sector. Not only did the Act failed
to secure a specific healthcare practitioner-identity for the traditional health practitioner, but is
the Act nothing less than an improper health act in conflict with the Constitution and various
other Acts like the Witchcraft Suppression Act (3 of 1957). Its impact on the South African Healthcare System holds only disempowerment and disaster for it, at present and in future. The Act, together with traditional health practitioners it had created, are both misfits in modern South Africa. Their impact do not contribute positively to empower the present and future South African healthcare system. Above negative outcome of the Act and the South African traditional health practitioners on the present and future South African healthcare sector was also confirmed by the five specific hypotheses (H1 to H5) (For detail description sees Chapters 4 to 8: Article 1 to 5). # The General Hypothesis HG must be rejected.

9.3 RECOMMENDATIONS

The following recommendations are offered, namely that:

- the Traditional Health Professions Act (22 of 2007) is revoked with immediate effect [this will lead to the automatic revoking of the Witchcraft Suppression Act of (3 of 1957) as a counteract to the Traditional Health Professions Act’s (22 of 2007) demonic intentions];
- the traditional healers are left unregulated;
- where applicable, the future training of traditional herbalists are directed into the careers of homeopaths, naturopaths and phytotherapists of the allied health professions; the future training of traditional diviners into the careers of psychologists with the Board of Psychology (HPCSA) and of social welfare practitioners with the Council for Social Work; and further training of traditional midwife attendants are directed into the career of midwives of the Nursing Council;
- a preliminary screening is offered to present-day traditional herbalists, traditional diviners and traditional midwife attendants to see if their present experience and training qualify them to write the examinations of the different professional Health Councils/boards that these bodies prescribe to newly qualified and foreigners practitioners when these persons want to register in South Africa. If they passed successfully, to allow them to register conditionally for a maximum period of five years;
- a campaign, starting on school level, to educate the public about healthcare services and professionals;
- a campaign is launched to educate the public about the dangers of supernatural, witchcraft and ritual activities on their personal and health life, and the exploiting of the public by scruple persons who pretend to can practice the supernatural, witchcraft, occult science and related crime-activities.
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ADDENDUMS A1 TO A5:

RESEARCH- AND DESCRIPTIVE-FOCUSSED ARTICLES

(Articles 1 to 5)
ADDENDUM A1:

PUBLISHED ARTICLE 1

(CHAPTER 4)

DOES THE TRADITIONAL HEALER HAVE A MODERN MEDICAL IDENTITY IN SOUTH AFRICA?


[Archives Australasian Medical Journal; Vol. 10 (2017), No. 2: Does the traditional healer have a modern medical identity in South Africa?]
Does the traditional healer have a modern medical identity in South Africa?

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RESEARCH

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ABSTRACT

Background

Research supports the view that the South African traditional healer does not hold a modern medical identity, but developed from the traditional African religions and cultural environment as a kind of caregiver. The name healer with a medical connotation arose from early colonists and missionaries misunderstanding the role of a traditional healer in Africa, especially in early South Africa. There is even a misunderstanding today about the African meaning of spiritual healing. As such, the traditional healer is a remnant from a previous, pre-modern time.

Traditional healers were forced to the foreground recently in South Africa by the Traditional Health Practitioners Act No 22 (2007). This act makes the traditional healer an exclusive healthcare practitioner with statutory status under the name traditional health practitioner. Such a healer can practice in the formal healthcare sector, including the public hospitals. The Act gives the healer the right to diagnose, treat and make, and prescribe pre-modern health products to his/hers clients unhindered. It is clear that the various resolutions and implementations of the Traditional Health Practitioners Act No 22 (2007) intend to bring the South African traditional healer into the practice domain of the South African medical doctor.
Aims
The study aimed to determine if the traditional healer has a medical identity in modern South Africa.

Methods
This is an exploratory and descriptive study that makes use of an historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on the traditional healer’s medical identity in modern South Africa. The findings are offered in narrative form.

Results
The New South Africa did not start changing socially, economically and politically after 1994. They have started to move into new cultural and life domains centuries ago. Some left behind many of the pre-modern beliefs, like the traditional healer and his supernatural activities and practices.

The present-day political and cultural pressure from politicians (with outdated thoughts) by means of things like the Traditional Health Practitioners Act No 22 (2007), are being met more and more with resistance by the broad population.

It is therefore important to research on the changes in cultural values and styles, economical positions and the medical needs of the country’s population to understand if the traditional healer has a truly medical identity in modern South Africa.

Conclusion
The Traditional Health Practitioners Act (No 22, 2007) has failed to include the outdated traditional healer into the modern South African society and formal healthcare sector as a specific medical entity. The foundations of South African society had changed too dramatically to allow space for a pre-modern cult practitioner.

Key Words
Identity, indigenous, oracle, priest, ritual, traditional healer, sorcery

What this study adds:

1. What is known about this subject?
The subject of traditional healing and the traditional healer has been researched at most superficially in South Africa, especially the medical entity of the traditional healer.

2. What new information is offered in this study?
This research offers a new view on the medical identity of the South African traditional healer.

3. What are the implications for research, policy, or practice?
The intention to confer a medical identity on the traditional health practitioner with the promulgation of the Traditional Health Practitioners Act No 22 (2007) seems to be short-sighted. The traditional healer lacks a clear medical distinctiveness. The intention of the South African authorities to enforce the traditional healer into the healthcare and medical establishments should be regarded with suspicion.

Background
Literature on the South African traditional healer, including the Traditional Health Practitioners Act No 22 (2007) and its definitions traditional medicine, traditional philosophy and traditional practice, include many references to the traditional healer’s medical identity. These references intimate that the traditional healer is a kind of medical entity and an essential part of the healthcare of Black South Africans, especially for those in the poorer rural areas.1,2

This alleged medical identity was clearly one of the main reasons for the promulgation of the Traditional Health Practitioners Act No 22 (2007). The concept of the belief in the supernatural that is specifically built into the Traditional Health Practitioners Act No 22 (2007), is seen as an exclusive part of the traditional healer’s health practice.1,2
The medical fraternity is very sceptical about the abilities, skills and diagnostic approaches of the traditional healer as a healthcare professional, especially in the medical sector.1,2

Other research shows that the claim that the traditional healers contribute to healthcare is untrue. The role of the traditional healer in the South African society as a healthcare worker of medical healer seems to be minimal. This includes all practice activities, like herbalism and divinity. In general only between 1.4 per cent of the population makes use of traditional healers, and since the 1990s there has been a constant decline in the demand for these services in South Africa.

The view that the traditional healer has a medical identity seems to be doubtful and needs further evaluation. The aim of this study is to determine if the traditional healer has a medical identity in modern South Africa.

Method

The research was done by means of a literature review. This method is aimed at building a viewpoint based on the available evidence as research on the subject developed over time. This approach is often used in modern historical research where there is a paucity of information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for the period 1989–2014, articles from 1982–2016, books from 1958–2013 and government documents covering the period 2007–2012. These sources stimulate reflection on the development of the Traditional Health Practitioners Act No 22 (2007) and its assumption of the medical identity of the traditional health Practitioner in modern South Africa.3,4

The findings are offered in the narrative form.

Results

Traditional healers’ lack in medical education and training The education and training of traditional healers in South Africa were and are still done in an informal manner. There are no education standards, formal learning programmes, established institutions, etc. There is no academic culture equal to that of the medical doctor. The traditional healers’ skills, competencies and abilities are of a much lower standard than those of the medical doctor in South Africa. In it not possible to be registered in terms of the Health Professions Act No 56 of 1974 as a kind of health practitioner with the Health Professions Council of South Africa (HPCSA) without adequate training. This medical culture is absent among the South African traditional healers. There is no evidence of an educational foundation on which to establish medical training programmes or to learn practical biomedical skills, including diagnosis and treatment in the near future.5–11

Erroneous names “medical” or “health” associated with the traditional healer in South Africa

The assumption that the South African traditional healer is a true medically trained healthcare professional, someone with a unique medical distinctiveness, similar to that of the medical doctor, seems to be untrue.9–13

The question is therefore: why is the traditional healer referred to in literature and even in the Traditional Health Practitioners Act No 22(2007) and viewed by a part of the public and the authorities in South Africa as a kind of medical doctor, traditional health practitioner, medicine man, traditional doctor, etc., if this is not the case? The reason is simply that these names, especially the name “traditional healer” (with the connotation of “medical” or “health”), is an erroneous name, introduced wrongly many years ago by the early colonists and missionaries of South Africa and accepted and offered in research as such since then. The South African “traditional healer” as we see and understand the term and the true role, abilities, training and position of the healer, has never been properly researched and defined. The name traditional healer has wrongly been included in the Traditional Health Practitioners Act No 22 (2007) to refer to a kind of medical practitioner. This deception was driven and established further by the traditional healing fraternity and their propagandists.9–11,14

An in-depth look into the writings of various independent African writers with deep African roots, like Mbiti,15 Boon,16 Gumede14 and Essien,17 clearly explain this mix-up and the misleading use of the name traditional healer in South Africa as a kind of medical practitioner instead of as a religious practitioner, like a priest or spiritualist. It is clear from their descriptions that the identity of the traditional healer is solely that of a religious practitioner. Essien17 clearly classifies the traditional healer as an inextricable component of traditional (old) African Religions. Essien17 sees the act of healing by the traditional healer as divine and not medical as the Traditional Health
Practitioners Act No 22 (2007) tries to profess. Essien\textsuperscript{17} reflects that the traditional healer’s healing acts are aimed at aiding human health by adjusting to superstition, magic and religious actions. The cures offered for diseases and illnesses, or any other kind of human health danger, are purely religious and supernatural treatments. It includes the use of “medicine” that Essien\textsuperscript{17} identifies as amulets, charms, herbs, sorcery, witchcraft and muti. The aim of this “medicine” is specifically to block out or to help avoid misfortunes, mishaps and sicknesses or to counteract sorcery and to put a stop to the evil spells of witches. Nowhere does Essien\textsuperscript{17} refer to modern or real scientific medicine, diagnoses and treatment.

Gumede\textsuperscript{14} also sees the traditional healer and his healing process as an integral part of religion. The healer is described as a “gifted man of God” and a parallel to the minister and evangelist. About the traditional healer’s prominent religious role during his home consultations, Gumede\textsuperscript{14,p.144} writes: “He opens proceedings with a prayer. The head of the family is requested to offer a goat – which is at the ready. The goat is killed by cutting the throat so that it bleeds. This rings a bell to summon all the clans. All the spirits of the departed ancestors are alerted to remain at attention. The head of the family then sings the praises of the old ancestral spirits or the chiefs departed. The traditional healer is performing his duties as the emissary of Umvelingqangi for he is both healer and priest.”

Gumede\textsuperscript{14} sees the approach of the traditional healer for as social, political, economical, moral, religious, recreation and they have a role when there is a change of environment. A true medicinal approach, based on modern medical science for diagnosis and treatment, is absent.

Boon\textsuperscript{16} defines the work role of the sangoma in particular and sees the traditional doctor, traditional healer or diviner as the term is used in the Traditional Health Practitioners Act No 22 (2007) as a priest-healer (meaning to heal or restore through spiritual actions) and not a medical healer treating biomedical conditions. This classification of the traditional healer as a priest, spiritualist, a seer and religious leader and not at all as a medical healer, is supported by the descriptions and definitions of many other researchers.\textsuperscript{18-23}

Mbti\textsuperscript{15}, whose research and writing played a dominant role in defining the so-called African traditional healer, indeed calls the traditional healer specifically a medicine man, but, he adds that this person is active in a total of eight religious roles in the African society, especially in the role of the priest. Mbti\textsuperscript{15,p.153} writes: “Religion has deep roots in people’s lives. Therefore, to make it function properly in society, there are often men and women who have religious knowledge, and who know how to lead others in religious activities, and who serve as the link between their fellow human beings on the one hand, and God, spirits, and invisible things, on the other. We find many such leaders in all African societies. Their knowledge of religious matters varies considerably. Some of them are professionals, and therefore well trained and skilled. Others only take the lead when the need arises, otherwise living and working like ordinary people. Some are rulers and national leaders, and it is their positions which embody religious beliefs and emotions. In many ways, religious leaders are the embodiment of what is best in a given religion. They embody the presence of God among people, and the faith or beliefs of the people, as well as their moral values. Without them, African religion would disintegrate into chaos and confusion. The religious leaders are the keepers of religious traditions and religious knowledge. They are wise, intelligent, and talented people, often with outstanding abilities and personalities. They include medicine men, diviners, mediums, seers, priests, ritual elders, rain-makers, and rulers”.

Both Mbti\textsuperscript{15} and Essien\textsuperscript{17} emphasize that all major diseases, illnesses and life troubles in the African society are usually regarded, treated and explained as religious experiences and not as biological/medical illnesses and diseases as modern medicine would understand it. For Mbti\textsuperscript{15} and Essien\textsuperscript{17}, contrary to modern medicine’s diagnosis and treatment, the muti of the traditional healer is essentially a religious act and a “ritual” needed to assure that life troubles, in the form of magic, sorcery, witchcraft, broken taboos and the work of spirits, are laid to rest.

Mbti’s\textsuperscript{15}, Boon’s,\textsuperscript{16} and Essien’s\textsuperscript{17} own misunderstandings of the true meaning of words like “medicine”, “medical”, “healer”, and their subsequent wrong use of these names for a religious priest or practitioner, is reflected by Mbti’s\textsuperscript{15} inappropriate description of the “African science of medicine”. In this description, he portrays the religious, pre-modern and supernatual training of his medicine man as based on a real medical foundation, similar to that of the modern medical doctor. The same misconception is also reflected by Mbti’s\textsuperscript{15} definition and understanding of the concept “protective” or “preventive” medicine, namely the use of muti for protection against misfortune (a
term that in modern medicine means: to inoculate with safe, effective and tested medicine to prevent an illness like poliomyelitis).

Mbiti’s\textsuperscript{15,p.156} uncleanness and lack of knowledge about what real modern medicine is, are also revealed by his naive remark that “medicine in African societies has a wider meaning”. He also tries to divert attention from the fact that “medicine in African societies” has no meaning similar to or connection to modern medicine and modern healthcare whatsoever in his definition\textsuperscript{15,pp.170-1} “For African people, the word medicine has a lot of meaning. It is unfortunate that in the English language it has a limited usage.” The truth is that Mbiti’s\textsuperscript{15} “medicine” is solely spiritual and his “medicine-man” is a spiritual healer.

**Discussion**

It is clear that the traditional healer and the pre-modern medical products that he prepares and uses as part of his treatment are far removed from modern biomedicine. He is not a health practitioner or medical doctor. However, the name “traditional healer” in reference to the pre-modern African milieu does not have any other meaning in modern society.\textsuperscript{24,25}

The medical meaning ascribed to the term traditional healer was endorsed from 1652 onwards in South Africa by a portion of the public, researchers and the lawmakers of the Traditional Health Practitioners Act No 22 (2007). Be that as it may, it is a misconception that has become a deception in our daily life.

It is clear that the role of the traditional healer, specifically as a skilled kind of medical practitioner in present-day South Africa, is minimal. His rituals, customs, practices and muti can primarily be associated with the supernatural, witchcraft, demons, bad magic, witches and other negative or problematic behaviours and doings, instead of scientific medical actions and healing.\textsuperscript{26-29}

The South African traditional healer is at most a priest or spiritualist: no medical role and identity can be allocated to him.

**Strength and limitations**

The findings of this research offer a clear definition of the traditional healer as a non-medical entity. The fixed and stereotypical thinking on the assumed medical abilities of the traditional healer will hamper new thinking and the correction of the view that the traditional healer is a medical practitioner.

**Conclusion**

It is clear that the traditional healers’ training, practices and treatments have been erroneously construed as medical over many years, while these practitioners are actually priests or spiritualists. There is a claim that traditional healers play a “distinctive” role as a kind of medical practitioner in the modern South African healthcare sector. However, role refers to an 11.2 per cent consultation rate in limited rural areas by a very small segment of poor people. The general usage of the traditional healer by the total population is only 1.4 per cent. This 1.4 per cent represents a maximum patient base of only between 75 801 and 607 041 persons. When it comes to consultations on truly “medical” problems, this number of users is even lower.\textsuperscript{2,30}

The maintenance of the medical identity of the traditional healer in South Africa by means of the Traditional Health Practitioners Act No 22 (2007) seems to be politically motivated. The post-1994 dispensation has given rise to political leaders and opportunistic politicians with masked agendas. They abuse the traditional healers by presenting them to the public as a so-called religious and cultural heritage that must be retained, playing on the emotions of the electorate. This unhealthy political climate is also abused by the traditional healers themselves to advance their own interests by means of the Traditional Health Practitioners Act No 22 (2007) and to promote their professional status as a kind of medical healer or practitioner. The traditional healer, with all his supernatural doings, is a pre-modern spiritual phenomenon with an ambiguous status.\textsuperscript{31-37}

The South African traditional healers’ assumed exclusive medical identity is non-existing in the modern South African society. The Traditional Health Practitioners Act No 22 (2007) is clearly inapplicable and inappropriate in its aim to accommodate and to regulate an outdated kind of pre- modern priest, spiritualist or caregiver as a kind of health or medical professional inside the formal health establishment of the country. This kind of registration belongs exclusively with churches, outside governmental healthcare regulation and relationship.
Emperor Theodosius declared in 400 AD about the evil doings of the oracles and wizards of Apollo that: \(^{38,p.110}\) “no mortal man shall have the effrontery to encourage vain hopes by the inspection of entrails, or to attempt to learn the future by the detestable consultation of oracles. The severest penalties await those who disobey.”

It seems as if the Traditional Health Practitioners Act No22 of 2007 AD had tragically pushed back South African traditional medicine nearly 3,000 years to 600 BC together with the oracles and wizards of Apollo.

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ADDENDUM A2:

PUBLISHED ARTICLE 2

(CHapter 5)

IS THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) IN CONFLICT WITH THE WITCHCRAFT SUPPRESSION ACT (3 OF 1957) IN PRESENT-DAY SOUTH AFRICA?

Is the Traditional Health Practitioners Act (No 22 of 2007) in conflict with the Witchcraft Suppression Act (No 3 of 1957) in present-day South Africa?

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ABSTRACT:

Background
The Traditional Health Practitioners Act (Act No 22, 2007) to regulate the traditional health fraternity had been driven since the 1960s and became a reality after the 1994 political change in South Africa. Although the Act was already promulgated in 2007 it is still not active. Certain definitions of the Act seemed to be very controversial; especially the role of the supernatural in healing that could be associated with witchcraft and criminal-related behaviour.

Aims
The aim is to determine if the Witchcraft Suppression Act (Act No 3, 1957) is discriminatory against the traditional healer as well as to determine if the Traditional Health Practitioners Act (No 22, 2007) and the traditional healer are contravening the regulations of Act No 3 (1957).

Methods
The exploratory and descriptive method was used to evaluate and to reproduce any research data. This method offered information to compare the two acts in their functioning with each other.

Results
From the data extracted from various sources it seems as if Act No 22 (2007) was promulgated without in-depth research on the role that the traditional healer may play in witchcraft activities. The aim of Act No 3 (1957) was totally ignored.
Conclusions

Act No 3 (1957) does not discriminate against Act No 22 (2007). Instead, it seems that various stipulations of Act No 3 have been transgressed by the traditional healers without legal action being taken against them.

Keywords

Discriminatory, law-enforcement, partial prosecution, scapegoating, supernatural, traditional philosophy, witch, witchcraft

What this study adds:

1. What is known about the subject?

No in-depth study has so far been undertaken to compare Act No 3 (1957) and Act No 22 (2007) with each other.

2. What new information is offered?

This study clearly reflects that Act No 3 (1957) is not discriminatory against Act No 22 (2007) as the traditional-health fraternity often tries to project.

3. What are the implications for research, policy, or practice?

That Act No 22 (2007) indeed holds intentions that may be associated with witchcraft and criminality.

Background

With the promulgation of the Traditional Health Practitioners Act (Act No 22, 2007), the South African lawmakers, activists and the traditional-healing fraternity established the statutory status of the traditional health practitioner and traditional healing as a health profession, totally and blindly ignoring the existence of the Witchcraft Suppression Act (Act No 3, 1957).

This erring seems to have serious implications for the traditional healer’s future ways of diagnosis, treatment as well as training. The supernatural, witchcraft, wizardry, etc. seem to be part of the traditional healer’s practice, activities which are illegal in terms of Act No 3 (1957). It seems also in terms of Act No 3 (1957)’s regulations as if some aspects of Act No 22 (2007)’s practice definitions are possibly illicit.

Act No 3 (1957) triggered much criticism by the traditional-healing fraternity. Already enacted in 1957 it went fairly unnoticed until 1994, seemingly because it was enacted by the apartheid regime and fitted in well with its legal and governmental thinking and rulings up to the new political dispensation of 1994. Opposition to it by dissidents were not possible or allowed. The Constitution of 1996 and the Bill of Rights brought the opportunity to object freely to any supposed human-rights violation. After 1996 opposition to the Act by individuals, human-rights activists, the neo-pagans and the traditional healers, became more demanding. Especially their agitation in terms of Section 5 of the Civil Union Act (No 17, 2006) and support by outsiders like the Lawyers for Human Rights (LHR) put them in the foreground. ¹, ², ³, ⁴, ⁵

The aim of this study is to determine if Act No 3 (1957) is discriminatory against the traditional healer as well as to determine if the Traditional Health Practitioners Act (No 22, 2007) and its traditional healers are contravening the regulations of Act No 3.

Methods

Research information and other literature on the legal standing of Act No 3 (1957) are very limited, besides the information published on the websites, journals and other publications by the neo-pagans, traditional healers and some individuals, reflecting their opinions, viewpoints, statements and own findings. This research strongly relied on this information, especially publications and appeals aimed at the South African Law Reform Commission (SALRC) to get the Act repealed.

In the light of the above information shortage, the exploratory and descriptive research method was used. It offered the researcher the opportunity to review and to consider new information as the research progressed. The narrative form is used to reflect the findings. ⁶, ⁷
Results

The traditional healer

Of all the role players that object in some way to Act No 3 (1957) the traditional healers seem to be the protagonists, based on the intentions of Act No 22 (2007) versus Act No 3 (1957) and the possible interrelation and conflict between these two Acts to regulate the traditional healer’s diagnosis, treatment and training.

In the following discussion the intentions of Act No 3 (1957) will be compared with that of Act No 22 (2007). Further, the diagnosis, treatment and training practices of the traditional healer as bestowed on and allowed by Act No 22 (2007) will be evaluated against the regulations of Act No 3 (1957) to see if it is legally correct or illicit.

The 1957 scapegoating of the witch and neo-pagans

In contrast to some individuals and the neo-pagans who want Act No 3 (1957) to be repealed as a whole without any further type of witchcraft legislation to replace it, the traditional-health fraternity is far more radical and wants Act No 3 (1957) to be replaced by a new but stricter law that strikes a balance between protecting innocent people accused of witchcraft and punishing those found guilty of practising witchcraft.

This inclination brings conflict between the South African Pagan Council (PCSA/SAPC) which sees witchcraft as a “noble practice” and the Traditional Healers Organisation (THO) which distances them from wizardry and who argues that witches and witchcraft should be punished with the full severity of the law.

The hostile and snobbish attitude and dissociation from the so-called “witch” and “witchcraft” (including thus neo-paganism) by the traditional-health fraternity, has a long history. It was created in 1957 by Act No 3 (1957) itself with its specific scapegoating of the witch (“wizard”) as the only criminal entity that commits witchcraft-related crimes, such as muthi, ritual, religious, cultural and other crimes (including murder), and thus the identity which can and must be prosecuted by a court of law. The viewpoint was sensationalised and driven over the years by the media, opportunistic religious and governmental groups and internalised in the minds of the public, notwithstanding if these assumptions were true or false. Through Act No 3 (1957)’s rule of law the “bad witch” was totally isolated as a stand-alone social, health, religious and cultural figure and a criminal-orientated practitioner that only intends to harm the innocent. [The 1957 Witchcraft Act: Available from http://www.quackdown.info/article/1957-witchcraft-act/ (accessed 19/10.2014) ]

The 1957 scapegoating declared the traditional healer unofficially as “good” or “bad” or a “witch”, distracting any attention from the traditional healer whose role in past, present and future could have negative connotations. The deviation between the other regulated health practitioners as “good” and the “witch” on the other hand as “bad” was grabbed and exacerbated by the opportunistic traditional healers; especially after the promulgation in 2007 of Act No 22 (2007).

The possibility of conflict between Act No 3 (1957) against Act No 22 (2007)

The present legal setup of the traditional healer sanctioned and certified as able by Act No 22 (2007) as a statutory healthcare practitioner, will be evaluated using the rules of Act No 3 (1957), specifically to see if there are cohesion and/or contradiction between the two Acts. For this it is important to state again the main aims of Act No 3 (1957), namely:

- To prevent any person or a community to identify a specific person (notwithstanding his position or doing, to justify such an identification) to be a “wizard” through witch-finding;
- To prevent that this identified person (“wizard”) is harmed (threatened, terrorised, victimised or even murdered) in anyway by the “witch-finder” or the community;
- To prevent a person to call himself a ‘wizard’ by prohibiting such self-naming / declaration as a crime, with the sole aim to safeguard him against harm by his own wrongdoing, to be identified as a ‘wizard’ by the ‘witch-finder’ and the community [see (a)]. [For full text see Section 1(a) to (f) (i) – (iv)].

Comparing the two Acts to determine if Act No 3 (1957) has negative effects on the activities of the traditional healer, two sets of data can be used: i) the witchcraft statistics of 1994 to 2004 of the 2006 Report of the South African Parliament and ii) the six descriptions of witchcraft offences in terms of Act No 3 (2007). These six offences are reflected later in Table 1.
The 2006 Parliamentary Report

The statistics of the 2006 report of the South African Parliament reflected that in 1994 only 13 persons were convicted on the accusation of having identified another person as a “wizard” and/or of actions to harm such an identified person as a “wizard”. In 2004, 10 years later and with seemingly a stricter implementation of the Act, these convictions rose to 345 cases (a rise of 332 or 96,2% in cases) [Officially the SAPS does not keep statistics specific to muthi or ritual assaults and murders; this limited an in-depth study on the matter, stretching from 1957 to the present. It forced thus the use of a few studies (like the 2006 report of Parliament)]. 14, 15, 16

The 2006 report shows that in 1994 only 10 cases of withdrawals, with nil acquittals, occurred; in 2004 there were as much as 567 cases of withdrawals and 141 of acquittals. (In the withdrawn cases the rise was 557 or 98,2% and in the acquittal cases the rise was 141 or 100%). 17, 18

It is also argued that the dramatic rise in the total registration of witchcraft-related cases in a period of 10 years – from only 23 (10 withdrawals, 14 convictions and nil acquittals) in 1994 to 1 053 (567 withdrawals, 345 convictions and 141 acquittals) in 2004 — by law-enforcement agencies like the South African Police Services (SAPS) and the National Prosecution Authority (NPA), that Act No 3 (1957) is an effective and working piece of legislation. Also, it is argued that these statistics, together with the law-enforcement bodies involved, confirms that Act No 3 (1957) is at all time in use. 19, 20, 21, 22

The opinion is that Act No 3 (1957) is not aimed at doing any harm or injustice to the law-abiding citizen, even when he transgresses some of the regulations of the Act, knowingly and wilfully. The Act is only focussed and applied in terms of its main aims: to prosecute only the individual with criminal intent who would normally be prosecuted under any of the other criminal codes for serious law-breaking. In terms of Act No 3 (1957) the context of the focus is the person who names, identifies and sniffs out any other person as a wizard and who intends to do or is involved in doing such person harm in some or other way. 23, 24, 25, 26, 27

The opinion is also that only certain sub-rules of the prescribed rule 1(a) to 1(f) are really implemented to prosecute: meaning that Act No 3 (1957) regulations are only partially executed to make prosecutions. To determine the true impact of this assumed executing of Section 1(a) to 1(f), is very difficult; seemingly governmental agencies do not refer specifically to witchcraft-related crime statistics or other research outcomes. The only guide to review the use of Act No 3 (1957) is the writings and appeals of the neo-pagans, individual objectors and other interest groups that are focussing their writings on the repeal of the Act, or who are doing research on the Act’s benefits and shortcomings. 28, 29, 30, 31, 32

In the evaluation in Table 1 the six main offences, as described by Section 1(a) to 1(f) of Act No 3 (1957), were compared with the statistics on witchcraft convictions of the 2006 report of Parliament for the period 1994 to 2004. 33, 34, 35, 36 These outcomes are reflected in Table 1:

Table 1: Six offences relating to witchcraft versus types of witchcraft-related convictions for the period 1994 to 2004:

<table>
<thead>
<tr>
<th>Description of Offences</th>
<th>Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Any person who imputes to any other person the causing, by supernatural means, of</td>
<td></td>
</tr>
<tr>
<td>any disease in or injury or damage to any person or thing or who names or indicates</td>
<td></td>
</tr>
<tr>
<td>any other person as a wizard</td>
<td></td>
</tr>
<tr>
<td>2. Any person who in circumstances indicating that he professes or pretends to use any</td>
<td></td>
</tr>
<tr>
<td>supernatural power, witchcraft, sorcery, enchantment or conjuration, imputes the</td>
<td></td>
</tr>
<tr>
<td>cause of death of, injury or grief to, disease in, damage to or disappearance of any</td>
<td></td>
</tr>
<tr>
<td>person or thing to any other person</td>
<td>None</td>
</tr>
</tbody>
</table>
Table 1 reflects that regarding three of the six types of offences (defined by Section 1 as law-breaking), convictions occurred. This brings to the foreground that not more than 50% of the prescribed offences have been activated to be prosecuted and thus that the opinion that Act No 3 (1957) is indeed only partially implemented, is correct.

The traditional healers can surely not object that Act No 3 (1957) is discriminatory. It can thus be concluded that the traditional healer’s practice is undisturbed by the Act.

The outcomes of Table 1 are vague and not fully informative about the alleged partial prosecution approach of the law-enforcement agencies. A more detailed analysis is needed. In this context it must be noted that the six offences, reflected in Section 1 of Act No 22, are compiled and described by the incorporation of different offence descriptions to obtain the six descriptions. These incorporated descriptions can lead to an over-simplifying interpretation about the partial or full-executing approach of Act No 3 (1957).

The re-written fourteen single offences

To obtain a more precise profile of a specific offence relating to a specific conviction, the above six offence descriptions were separated from each other where they are unrelated in terms of legal meaning. The offences were re-written to reflect specific (single) offences only. With this focussed approach 14 single offences, relating to the practice of witchcraft, were identified and described. In Table 2 these 14 offences relating to witchcraft were compared with the witchcraft statistics of the 2006 Parliamentary Report for the period 1994 to 2004.

Table 2: Description of Offences and Convictions

<table>
<thead>
<tr>
<th>Description of Offences</th>
<th>Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Any person who employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard</td>
<td>Convictions</td>
</tr>
<tr>
<td>4 Any person who professes a knowledge of witchcraft, or the uses 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</td>
<td>None</td>
</tr>
<tr>
<td>5 Any person who on the advice of any witchdoctor, 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</td>
<td>Convictions</td>
</tr>
<tr>
<td>6 Any person who 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</td>
<td>None</td>
</tr>
</tbody>
</table>

To put into perspective, the rules of Act No 3 (1957) and Act No 22 (2007) with each other, Section 1 (Offences relating to the practice of witchcraft and similar practices) of Act No 3 (1957) is again, as was done in Table 2, reproduced for clarity hereunder in 14 sub-descriptions. In terms of Section 1(a) to 1(f) an offence will be committed by any person who: 43, 44
• Imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing;
• names or indicates any other person as a wizard; in circumstances indicating that he professes any supernatural power, witchcraft, sorcery, enchantment or conjuration;
• in circumstances indicating that he 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;
• employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard;
• professes a knowledge of witchcraft, to bewitch, injure or damage any person or thing; advises any person with any pretended means of witchcraft;
• supplies any person with any pretended means of witchcraft;
• on the advice of any witchdoctor, witch-finder or other person 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;
• 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;
• for gain pretends to exercise or use any supernatural power, witchcraft, sorcery, enchantment or conjuration;
• for gain undertakes to tell fortunes;
• for gain 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.

Table 2: Fourteen offences relating to witchcraft versus types of witchcraft-related convictions for the period 1994 to 2004:

<table>
<thead>
<tr>
<th>Description of Offences</th>
<th>Convictions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Any person who imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing</td>
<td>None</td>
</tr>
<tr>
<td>2 Any person who names or indicates any other person as a wizard</td>
<td>Convictions</td>
</tr>
<tr>
<td>3 Any person who in circumstances indicating that he professes any supernatural power, witchcraft, sorcery, enchantment or conjuration;</td>
<td>None</td>
</tr>
<tr>
<td>4 Any person who in circumstances indicating that he pretends to use any supernatural power, witchcraft, sorcery, enchantment or conjuration;</td>
<td>None</td>
</tr>
<tr>
<td>Description of Offences</td>
<td>Convictions</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>5  Any person who 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;</td>
<td>None</td>
</tr>
<tr>
<td>6  Any person who employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard;</td>
<td>Convictions</td>
</tr>
<tr>
<td>7  Any person who professes a knowledge of witchcraft, to bewitch, injure or damage any person or thing;</td>
<td>None</td>
</tr>
<tr>
<td>8  Any person who advises any person with any pretended means of witchcraft</td>
<td>None</td>
</tr>
<tr>
<td>9  Any person who supplies any person with any pretended means of witchcraft</td>
<td>None</td>
</tr>
<tr>
<td>10 Any person who on the advice of any witchdoctor, witch-finder or other person 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</td>
<td>Convictions</td>
</tr>
<tr>
<td>11 Any person who 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</td>
<td>None</td>
</tr>
<tr>
<td>12 Any person who for gain pretends to exercise or use any supernatural power, witchcraft, sorcery, enchantment or conjuration</td>
<td>None</td>
</tr>
<tr>
<td>13 Any person who for gain undertakes to tell fortunes</td>
<td>None</td>
</tr>
<tr>
<td>14 Any person who for gain pretends from his skill in or knowledge of any occult science to discover where and in what manner</td>
<td>None</td>
</tr>
</tbody>
</table>

Table 2 reveals only three offences with convictions out of the 14 offences, meaning so much as 78.5% of the regulations were apparently not use in law-enforcement. This is in line with the opinion obtained in Table 1 that concludes that Act No 3 (1957) is only partially applied to make prosecutions and to obtain convictions. It again confirms that Act No 3 (1957) is not discriminating against the traditional healer.

It seems from the outcomes of this sub-division that Act No 3 (1957) benefits society and the individual specifically, overshadowing its prejudice. The view that the Act is only in part applied and then only to bring true criminality to
book, supports the opinion that the constitutional rights of the individual or even the group are not transgressed. These outcomes seem to declare why the South African Law Reform commission (SALRC) and the government itself are hesitating to repeal it, seeing that the Act fulfils its main aims to protect the individual.

**Act No 22 (2007) and criminal intentions in perspective**

With reference to Act No 22 (2007)’s rules, the practice of the traditional healer is determined in terms of two definitions, namely the definitions of traditional health practice and traditional philosophy in Chapter 1 of the Act. Traditional health practice means the following: “The performance of a function, activity, process or service based on a traditional philosophy that includes the utilisation of traditional medicine or traditional practice”, while traditional philosophy incorporates the following sub-definitions:

- indigenous African techniques;
- indigenous African principles;
- indigenous African theories;
- indigenous African ideologies;
- indigenous African beliefs;
- indigenous African opinions;
- indigenous African customs;
- (i) The uses of traditional medicine communicated from ancestors to descendants or (ii) from generations to generations, with or without written documentation, whether supported by science or not.

It is clear, although it is not verbally described as such, that the supernatural plays a dominant role in the traditional health practice as the reference “communicated from ancestors to descendants” in the definition clearly indicates a traditional philosophy. This masked role of the supernatural in the practice of the traditional healer is specifically supported by the definitions of indigenous African theories, ideologies, beliefs, principles, opinions and customs as described in the traditional philosophy. The reference to “the existence of traditional medicine without written documentation, whether supported by science or not”, brings the presence of occult science in the traditional practice of the traditional healer to the foreground.

**The healer’s activities in perspective**

Act No 22’s (2007) definitions of traditional health practice and traditional philosophy fail to offer formal, in-depth descriptions on the diagnosis and treatment processes of the traditional healer and thus any doings that can be in conflict with Act No 3 (1957). To overcome this lack in information and to can reflect on the diagnosis and treatment processes of the traditional healer, the descriptions offered by thirteen independent researchers and experts on the traditional healer’s practice in South Africa, were compiled. Here-through it was possible to profile the true diagnosis and treatment of the traditional healer and to can use it as a guideline to evaluate the possibility of the transgressing of the regulations of Act No 3 (1957). This profile of the thirteen researchers (identified by names) is reflected later in Table 3.

**Possible supernatural practice activities and legal transgressing by the traditional healer of the rules of Act No 3 (1957)**

To obtain a decision if the traditional healer’s diagnoses, treatment and training practices contravene the fourteen offence-rules of Section 1 of Act No 3 (1957), these fourteen offences are reflected under in Table 3 (see also Table 2) against the specific descriptions by the thirteen researchers. The researchers’ names were reflected in Table 3 when they referred to processes that correlate to the actions of the traditional healer. 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56

Table 3: Fourteen offences relating to the practice of witchcraft versus the diagnosis, treatment and training processes of the traditional healer for the period 1994 to 2004, as identified by thirteen independent researchers:
Table 3: Fourteen offences relating to the practice of witchcraft versus the diagnosis, treatment and training processes of the traditional healer for the period 1994 to 2004, as identified by thirteen independent researchers:

<table>
<thead>
<tr>
<th>Description of Offences</th>
<th>Names of Researchers</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Any person who imputes to any other person the causing, by supernatural means, of any disease in or injury or damage to any person or thing</td>
<td>Essien, 2013; Hofstatter, 2014; “Traditional African medicine”, 2014; Truter, 2007</td>
</tr>
<tr>
<td>2 Any person who names or indicates any other person as a wizard</td>
<td>None</td>
</tr>
<tr>
<td>4 Any person who in circumstances indicating that he pretends to use any supernatural power, witchcraft, sorcery, enchantment or conjuration</td>
<td>Mbiti, 1991; Onwuanibe, 1979; “South African Traditional”, 2014; “Traditional African Medicine, 2014; “Traditional healers of”, 2014; Truter, 2007</td>
</tr>
<tr>
<td>5 Any person who imputes the cause of death of, injury or grief to, disease in, damage to or disappearance of any person or thing</td>
<td>Hofstatter, 2014; Truter, 2007</td>
</tr>
<tr>
<td>6 Any person who employs or solicits any witchdoctor, witch-finder or any other person to name or indicate any person as a wizard</td>
<td>None</td>
</tr>
<tr>
<td>7 Any person who professes a knowledge of witchcraft, to bewitch, injure or damage any person or thing</td>
<td>Hofstatter, 2014; “Traditional African medicine”, 2014; Truter, 2007</td>
</tr>
<tr>
<td>8 Any person who advises any person with any pretended means of witchcraft</td>
<td>None</td>
</tr>
<tr>
<td>9 Any person who supplies any person with any pretended means of witchcraft</td>
<td>Hofstatter, 2014; Truter, 2007</td>
</tr>
<tr>
<td>10 Any person who on the advice of any witchdoctor, witch-finder or other person 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</td>
<td>None</td>
</tr>
</tbody>
</table>
From Table 3 it is clear that regarding only four out of fourteen (28.5%) offences the traditional healers are not implicated, namely regarding the offence to indicate another person as a “wizard” (no. 2), employs or solicits a witch, witch-finder, etc., to name or to indicate another person as a “wizard” (no. 6), advises another person to bewitch, injure or damage another person (no. 8), and the use of advice by a witchdoctor, witch-finder, etc. to injure or to damage any other person (no. 10).

As to the correlations between the offences and the descriptions of researchers as reflected by Table 3, as much as 71.4% of the descriptions indicate that there can be or are transgressions of Act No 3 (1957)’s fourteen criteria for offences. All thirteen the researchers reproduce in their descriptions in some way an overlapping between the practice processes of the traditional healer and the offences of Section 1 of Act No 3 (1957).

Discussion

The traditional healer’s image of himself as only “good” against the witch as only “bad”, mistakenly created by Act No 3 (1957) in 1957, is wrong and opportunistic. Evidence is overwhelming that his practice processes are based on the supernatural, that he professes and indicates himself that he uses supernatural powers, that he does fortune-telling, occult science, supplies in certain circumstances his clients with means of witchcraft and that he intends to harm, injure and even kill other people. The 1957 identification of the witch as a sole entity and as a reality is thus incorrect. There is no guarantee whatsoever that the traditional healer is not involved in witchcraft-related crimes, like ritual, muthi, religious, cultural and revenge murders. The pointing out by researchers of the traditional healer, with elements in the police, politics, religion, as the real culprits who are committing witchcraft crimes, is thus not far-fetched. 57, 58, 59, 4, 11, 28

It is clear that Act No 22 (2007) was promulgated without an in-depth understanding of the already fixed offences of Act No 3 (1957). Basically this makes Act No 3 (1957), as confirmed by this research (see Table 3), Act No 22 (2007) null and void. It is time that the lawmakers revisit Act No 22 (2007) to look to its legitimacy as a law.

Act No 3 (1957) is of cardinal importance to counteract the dangers of the traditional healer’s practice processes. It is an important criminal law, constitution-friendly and thus cannot be repealed. Indeed, it can be made more comprehensive to combat the criminal intention of the traditional healer. In comparison Act No 22 (2007) is an improper Act that offers opportunities for criminal behaviour and must be repealed because it is in conflict with Act No 3 (1957).
It is clear that Act No 22 (2007) was meant for an established healthcare profession, one with clearly defined, legally correct practice processes. In contrast, the traditional healers failed all the standard rules required by a statutory healthcare profession. It interferes with the privileges and rights of the already-registered health professions. The Act also confirms that the traditional healer’s entrance into the established health facilities of the country and to practice a health service he is not trained for or capable of executing, was a mistake.

Act No 3 (1957) reflects further shortcomings in relation to Act No 22 (2007) and the doubtful status of the traditional healer as a “good” health practitioner. It indeed confirms that certain of the beliefs and activities of the traditional healer are based on the supernatural, future-telling and even occult science, etc., all outcomes that are illicit in terms of Act No 3 (1957).

**Strength and limitations**

The exploratory and descriptive research approach of this study successfully built a viewpoint on the positive role of Act No 3 (1957) in combating witchcraft in South Africa. This research approach also helped to position for the first time Act No 22 (2007) versus Act No 3 (1957).

The well-established position of Act No 22 (2007), based on “African Culture”, politically favoured since 1994 and the successful “scape-goating” of Act No 3 (1957) as a pre-1994 discriminatory piece of legislation, is going to mute the findings of this study.

**Conclusions**

Act No 3 (1957) is not discriminatory against the practice behaviour of the traditional healer or the regulations of Act No 22 (2007) which determined the professional status of traditional healing in South Africa. On the contrary, Act No 3 (1957) is very accommodating of the misbehaviour and malpractice of the traditional healer.

Some of Act No 22 (2007)’s regulations seem to stand in conflict with certain of the regulations of Act No 3 (1957), while the traditional healer’s practice activities seem also to violate extensively some of the regulations of Act No 3 (1957) which determine criminal behaviour.

Act No 22 (2007) is an improper Act, an unacceptable reality in modern-day South Africa and must be repealed and not Act No 3 (1957). Act No 22 (2007) seems to be a true dolus eventualis case for the South African Constitutional Court in the near future.

**References**

7. Louw GP. A guideline for the preparation, writing and assessment of article-format masters dissertations and doctoral theses. Faculty Education: Mafikeng Campus: North-West University; 2013.

Conflict of interest
The authors do not have any financial or personal conflict of interest to declare.

Declaration
All the information contained in this manuscript has not been presented elsewhere.

Notes:


7. Louw GP. A guideline for the preparation, writing and assessment of article-format masters dissertations and doctoral theses. Faculty Education: Mafikeng Campus: North-West University; 2013.


9. ibid.


ADDENDUM A3:

PUBLISHED ARTICLE 3

(CHAPTER 6)

THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007): A SOUTH AFRICAN CONSTITUTIONAL MISHAP?

The Traditional Health Practitioners Act (No 22 of 2007): A South African Constitutional Mishap?

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ABSTRACT

Background
The Traditional Health Practitioners Act (Act No 22, 2007), which elicits controversy in the South African healthcare and public sector since proclamation, went untested through the legislature, driven inside the post-1994 socio-political dispe

Aims
The aim of this study was to determine and to reflect the Act’s long term legal implications for the already statutory health professions and the public: specific with the focus on the Constitution and other legislations and possible ways to oppose it.

Methods
This is an exploratory and descriptive research, in line with the modern-day history approach of investigation and reviewing research, using contemporary reports, newspapers and articles as primary resources to reflect on the situation, thinking, opinions, trends and activities around Act No 22 and its implications on the Constitution and citizen’s rights. The focus was also to put Act No 22 in a future in perspective. Findings are represented in narrative form.
Results

Act No 22 (2007) was promulgated without an applicable and appropriate scientific needs-analysis. The Act seems to stand to a great extent in conflict with the Constitution as well as various other Acts, like the Witchcraft Suppression Act (No 3, 1957).

Conclusions

The Act is still today, nearly a decade after promulgation, not fully active. It is a Constitutional mishap. Notwithstanding its constitutional controversy, the Act’s political sanction by governmental agencies and political leaders will ensure that it will not vanish easily from the South African law books.

Keywords

Apartheid, constitution, human rights, post-1994 dispensation, traditional healer and religions

What this study adds:

1. What is known about the subject?

Little research was done on the possible transgressing by Act No 22 of the South African Constitution and the possibility in future of misuses by the traditional healing fraternity of Act No 22 to benefit their quackery.

2. What new information is offered by this study?

It clearly described the legal misinterpretations of the Constitution by the traditional healing fraternity to serve their improper interests.

3. What are the implications for research, policy, or practice?

The status of traditional healing as a statutory profession is in doubt; the same can be said of the legal status of Act No 22.

Background

Act no 22 (2007) was shaped by two strategy manifestos of the African National Congress (ANC), namely the Manifesto of the National Democratic Revolution (NDR) of 1969 and the National Health Plan (NHP) of 1994. Never was there over the years deviated an inch from these master-plans in the execution of political and cultural preferences, notwithstanding sound logical, legal and financial argumentation against it. This fixed viewpoint malformed thinking around the true rights of individuals and groups, democracy and the correct interpretation of the various clauses of the Constitution.

The aim of this exploratory and descriptive research was to determine if the impact of Act No 22 (2008) on the Constitution and other South African Acts can makes these laws mal-functioning.

Methods

Books and articles on the South African traditional healing are very limited; it offers mostly trivial, old, and superficial information. This lack of sound and in-depth research findings on the traditional healer in the Republic of South Africa (RSA) had necessitated a study that builds a viewpoint and forms a conclusion from the ground, derived directly from the evidence as it appears as the research developed. The exploratory and descriptive research approach, as used in modern-day historical studies of investigation and reviewing information, was the most appropriate. Here-through contemporary newspapers, reports and articles were used as primary resources to reflect on the impact of Act No 22 and traditional healing on specific the functioning of the Constitution as well as the present-day life of South Africans. The findings are offered in narrative form.

Results

Act No 22 (2007) is still untested today

A good indication of the political skim-off and misdirected thinking and doing in general since the early 1960s on the traditional healer’s competence, is reflected by the designing and compiling of Act 22. An in- depth study to determine the true needs and applicability of the Act was never done. The problem was side-stepped with two superficial enquiries, supported by various road shows between 1997 and 1998.
The final decision to construct the Act was based on the outcome of five basic questions, put to the public. They are:

- The desirability of a statutory council for traditional healers;
- The recognition of medical certificates, issued by traditional healers;
- The recognition of the claims of traditional healers by medical schemes; The formal legal recognition of traditional healers as a medical source;
- The establishment of an interim council for the regulation of traditional healers as a health profession.

Negative indicators about the traditional health practitioner’s future statutory recognizing in terms of Act No 22 (2007), as well as the future regulation of traditional healing as a formal healthcare sector, were not thoroughly considered in the proposal of the Act. Specific a lack in need for traditional healers, various non-described-types of traditional healers in practice, a lack of present-day formal training programs, training standards and a functioning system, risks of traditional treatment and concoctions to the public and the health sector, the negative effect of the traditional healer on the practices of the already statutory recognized health practitioners, especially medical doctors, as well as a lack on in-depth research on the possible negative role to play in healthcare, were ignored. Thoughts how to incorporate the traditional healer into the already established allied professions, like homoeopathy, naturopathy, phytotherapy and ethno-medicine, and thus to avoid duplication in training and health practitioner-types, as well the limiting of the immense development costs around the separate recognition of the traditional healer, were also ignored.

This legalizing of traditional healing into the established health sector, was driven under the banner of Section 31(1) of the Constitution of South Africa. This regulation, it was argued, declares that every person, belonging to a cultural community, may not be denied, together with the other members of his community, the right to enjoy their culture. This clause was and is still interpreted by the propagandists of traditional healing as the bestowing of unchallengeable constitutional rights on the traditional healer to practice his trade. It is also argued that it offers the right for the community, to whom the healer belongs, to demand for his services and to use exclusive his services as traditional healer.

These beliefs by the traditional healer and his followers in his right to be an official health provider and to may practice freely and fully at all time his trade, were further driven and supported by the Patients Charter 2002 of the Department of Health (DOH). This Charter emphasis the right of patients to be free to choose a particular type of healthcare practitioner for services, notwithstanding the practitioner’s risk impact to healthcare or the user’s life. It seems in this context as if the Charter itself can be a constitutional mishap, as Act No 22 (2007) seems already is doing.

Present-day law-transgressing by offering official work and training appointments to traditional healers

The above opportunistic and scornful attitudes about the alleged rights and status of the traditional healer, as reflected inside as well as outside the traditional healthcare setup, led thereto that various governmental, semi-governmental and other agencies and bodies had even signed legal agreements with traditional healers to work in an official health team or to formally train traditional healers. Examples of these agreements are with a well-known university and two prominent municipalities. One of these municipalities appointed traditional medicine managers to integrate traditional healing and allopathic medicine in its health system and to promote two-way referrals and collaboration between the municipal’s clinics and traditional healers. The University is alleged to have a traditional healer on its staff, working in its counseling and wellness-program. These actions are alarming and irresponsible; it is risky and must be evaluated against.

In retrospect, it must be noted, that, all though Act 22 (2007) was promulgated, the Act is not fully activated at this stage (2016) regarding a functioning register for traditional healers. It is thus still illegal, in terms of the various Health Acts, for the already registered health practitioners to work with the unregistered traditional healer. Anybody, municipality, university or individual, doing so, put the health and life of their patients at risk and will not have any indemnity against lawsuits for malpractice with this delinquent behaviour.
**Subtle misuses of legal definitions in self-promotion and reflecting of possession of ability by the traditional healer**

Indirect law-transgressing is further well illustrated in the misuses of certain clauses of the Constitution, the Civil Union Act (No 17, 2007), as well as Act No 22 by the traditional fraternity to present themselves to the public as skilled and thus acceptable by the statutory healthcare.

Here it is specific the actions of certain traditional healers organizations which reflect these misuses of the Constitution very well in their public ethic-declarations and practice-rights communications. Specific are those clauses hauled in under the traditional healings umbrella of “exclusive rights to can and may practice”, with the misleading prefix in the Constitution that stipulates that “everyone has a right to equality, human dignity, free association, privacy, religion, beliefs and opinions, trade preferences, occupations and professions, preference life-styles, fair labour practices and access to preferred healthcare”, notwithstanding that they are knowing very well that these clauses are not fully applicable on the traditional healers unscientific and risky practices.

These legal misuses are also very subtle reflected by traditional health fraternity communications in their efforts to drag in Act No 22’s description of the representative of the Health Professional Council of South Africa (HPCSA) the formal recognition of traditional healing by the medical and pharmaceutical fraternities. The impression is also subtle left that the HPCSA and SAPC recognize the traditional healer as an independent health practitioner, notwithstanding that traditional healers know very well that these representatives, sitting on the THPCSA, is required by Section 7 of Act No 22 solely to oversee that the THPCSA and its practitioners are not violating the legal rights and privileges of the already statutory recognized health practitioners.

**Constitutional misuses have limits, even for the traditional healer in New South Africa**

Constitutional misuses have limits; it also does not give free-booting to the traditional healer to practice as he feels. First, because he is still an unregulated practitioner, one who is clearly violating many of the country’s health laws and as such must be controlled. Second, because other citizens of South Africa also have rights, privileges and freedom, equal to that of the traditional healer, which must be protected. Sections 12(2) and 32(1) (b) of Act No 108 (1992), a pre-1994 version of the Constitution, are clear and loud about this.

There is great difference between private and public rights, with the last mentioned as favoured. Differences and uniqueness in culture, person, finance and lifestyles between South Africans, as the traditional healer tries to profess about him self since 1994, cannot be addressed or solved by misuses of the Constitution, as the government blindly did with the promulgation of Act No 22 and the official recognition of the traditional healer. Not even the Constitution can bring equality, as the academic and human activist, Dr Danny Titus, clearly point-out when he states that South Africans cannot argue away their true differences with the argument that everyone is equal before the law: South Africans are just too unequal and need another address for individual rights.

The Nobel-laureate Milton Freedman also warned long ago that a society that considers bluntly equality higher than the individual’s freedom [in this case safe medicines versus medical concoctions], will end without any one of the two.

It seems as if there is confusion in the mind-sets of the post-1994 government about outright equality for every South African and to how to differentiate when conferring such a right. It is ill-considered to give unlimited rights to a specific individual, here the traditional healer, knowing well the person can be a danger to the health of others.

Constitution experts, Prof. Marinus Wiechers and Prof. Koos Malan, identified clearly this mind-set, which allows that the law-abiding, good and sound person’s rights and claims are sacrificed, to serve a pretended ideal state of equality. Malan pinpoints this pretended equal-state not as a correction-action-state, but as a consuming-governmental-state, that devastating all justice doings. The intention is the disregard of all the rights and claims of the good as well as the problematic individual. This devastator, it seems, is now inside formal healthcare with the traditional healer and Act No 22.62-64

**Act No 22 is political, not cultural orientated**

It is argued by the propagandists of traditional healing that traditional healing is an essential cultural demand by the South African society, free of politics. The NDR (1969) contradicts this free of political meddling argument. This
political document, which had given birth to Act No 22 and formulated in the Apartheid regime’s most notorious time of the suppression of the South African majority, clearly had as an aim and a vision the establishment of pro-African healthcare services and institutes, one that includes traditional healing.1-3,6,8,10-13,17,24,28,29,33-38,49,65,66

The whole 1969-thinking was executed by a small, in exiled political leadership, who empowered themselves to think, right or wrong, on behalf of the voiceless and vote-less majority at home; an autocratic decision-making, possible acceptable by the majority in that time of suffering and uncertainty. But the demolishing of Apartheid in 1994 and the end of barriers on political, economical, educational and healthcare, brought political rights in decision-making direct to the till-then side-lined majority. These changes also brought enormous new mind-sets, more and more away from the 1969 autocratic leadership’s thinking, especially on the outdated healthcare, cultural and political thinking of 1969. South Africans, now free to think as they choose, become modern, also in their healthcare use. Traditional healing, together with other pre-modern remnants of healings and religions, disappeared from their mindsets.64,68-75,125

Hereto it seems that the 1969-leadership, now elders but with some still in political power, failed to change also and hang on to outdated and warped thinking on the supernatural, witches and traditional healing; not only because they believe in it, but primary because they see it as a matter to stay in power and to serve self-interests. Act No 22 is such a political behavioral-upkeep, notwithstanding that these leaders knowingly transgress Article 16 of the Constitution and the Code of Ethics for Members of the Executive, as prescribed by the Ethics Act (No 82, 1990).4,49,51,55,67,76-87

Is Act No 22 (2007) a Constitutional mishap?

Act No 22 was a well-planned legal and promotion exercise which will bring the pre-modern traditional healer inside the formal health sector, equal to the modern-day health practitioner. This all-over-forcing- down of the traditional healer, also shows the official disregard for the poor, uneducated individual, who is not only deprived by the government of medical and life-aids, but is now also left with the unscrupulous traditional healer and his dangerous concoction. 4,49,51,55,67,76-87

Only the post-1994 government’s immediate personal and political interests are served with the recognition of the traditional healer: its recognition as a specific healer’s type is not equal to the uplifting of the poor or uneducated individual. Uplifting, equality and non-discrimination are three separate entities; to be a sole entity, uplifting and non-discrimination are prerequisites, not ill-considered equality as the government tries to do. To stretch certain clauses of the Constitution, Act No 22 and other legal rules to promote and to establish traditional healing, are dangerous.49,59,62-64,88-90

The present constitutional mishap of the South African political-legal system cuts to the heart of a society still under construction. This mishap forced emeritus-judge Bernard Ngoepe to react on how the Constitution is misunderstood, misused and disrespected, by saying that some South Africans think that the Constitution gives them rights without limitations, an excuse through which they can get everything for nothing. It is clear for Ngoepe that some South Africans, the public as well as politicians, have a problem in the way they understand and apply the Constitution. Act No 22 and traditional healing is surely such an example.91,92

Opposition in the past to Act No 22

Opposition to the Act was so far minimal, notwithstanding the serious consequences it holds for the established health practitioners, especially the medical doctor. This poor reaction to the Act can be described to various obstructions:

*First, critic on the government is choked; summarily ignored and executive decisions are taken one-sided, basically of the overpowering majority of the ANC in the Parliament.18,21,49,89

*Second, critic from especially journalists and academics, is strong, but with very little positive outcome. In this concern there is always the fear of victimizing. At the moment these objection-actions seem just not strong enough to obtain a turn-around. More organized actions are needed, but the question is what really can be done to nullify Act No 22 (2007).93-96
**Possible future actions against Act No 22**

**Submissions to Parliament**

It is doubtful if any sympathy would be found at Parliament and its lawmakers for the repealing of the Act, seeing that it was they who had put the present Act through Parliament in 2003 and did nothing to oppose it. The present ANC-led government’s disrespect for the Constitution and basic rights on health safety, as the traditional healer demonstrates, together with rejections of appeal to rectify one-sided decisions, will surely makes any direct appeal by the medical fraternity to Parliament on the Act nil and void. This concern is confirmed by the action of Parliament to ignore the legal presence of the Witchcraft Suppression Act (NO 3, 1957) when promulgation Act No 22 (2007). Also the bluntly ignoring of the rights of the established healthcare professions, when parliamentarians activating the traditional healer as a formal health practitioner, serves as a further reminder of no interest to repeal Act No 22.

The fact that the present ANC-government is going to stay in power for at least another 20 years, re-confirms that the Parliament is not an ideal pathway to take. Also the fact that some of the top-members of the government themselves believe in the supernatural and interference by the ancestors, rules out on its own any anti-action in Parliament against the Act.

It must further be remembered that the public had lost trust in the Parliament to solve their problems, like the constitutional mishap Act No 22, long ago. This is confirmed by two research polls, namely the 2014 IPSOS-Poll and 2014 Media 24-Poll. These studies show that between 53% and 89% of the population distrust the Parliament and government. Taken action and taking on the Parliament on Act No 22, seems to be worthless.

**Court actions**

Another option to take on Act No 22 and against the present-day government, are through direct court actions. So far the Act went unchallenged in court, although there seems a lot of violation of the rights and practices of the already statutory health professions. In this concern is important to note that South African Courts are not very willing to give judgments on controversial political and cultural issues, like Act No 22 and traditional healing. Here, the medical fraternity’s own sad experience of the side-kicking of the Doctors for Life (DFL)'s legal action in 2003 with the Traditional Health Practitioners Bill, is still too fresh in their minds to readily re-engage in court-actions.

Similar to the above mentioned negative experience of the DFL, it must be noted that a 2014 Media 24-Poll had found that as so much as 78% of the population does not trust South African Courts fully. This negative inclination surely also effects the medical fraternity to rethink before they decide to take on Act No 22 (2007) in a legal battle. As learn from the DFL-case, the outcome can also be negative for them.

The hesitation of the medical fraternity to take legal actions must also be seen from the point that Act No 22 is still in limbo and can thus not effectively be taken on in court. The implementation that certain Sections of the Act to commence, was only done on 1 May 2014 and was limited to the establishment of the Interim Traditional Health Practitioners Council and the providing of a regulatory framework to ensure the efficacy and quality of traditional core services. This limits legal reaction. Recourse to courts of law by the medical fraternity is thus difficult at this stage, seeing that there is no real legal and physical endangering at present by Act No 22. As soon as the traditional healer enters physical the health services and establishment, claims from medical aid funds and will make him/her guilty of improper behaviour, organized court-actions from the medical profession can be expected.

**Informal ways to address Act No 22**

The experience of the author to motivate healthcare practitioners to address their professional dilemmas themselves, were disappointing and it is doubted if a well-organized formal reaction against Act No 22 will be ever realized. It is clear that other ways must be found and followed, outside the formal venues to address the Act. For this input not only individual, but also class-actions are needed, like the intensively use of the public and private media, in-depth research on the Act, traditional health and its impact on the healthcare sector. Strikes and walkouts, so commonly and effective to everyday-life in South Africa, seems a very appropriate and effective alternative for the up till now passive allopathic practitioners to be followed.
Discussion

It is the duty of the South African government to ensure that a specific healthcare or spiritual practitioner, in this case the traditional healer who is at most a spiritual caregiver, does not transgress any established legislations in his practice, either against the individual or a group. It also must be seen that the health practitioner do not endanger the health or the life of the user of his/her services or medicines. These prerequisites failed outright with Act No 22 (2007). Never in South Africa’s history was on the priest conferred statutory healer status or religion groups official regulated.

The Act is one of the many inapplicable, inappropriate and unworkable Acts that were put through Parliament since 1994, as Prof Piet Naude, Director of University Stellenbosch Business School (USB), reflects when he alluded that our politicians not always paid respect for Parliament and that they make acts which do not pass the test and must again and again be revised. The fact that Act No 22 is still not fully functioning, although promulgated in 2007, confirms that it did not passes the test of good legislation up to today. 118,119

Strength and limitations

Enough information was available to formulate and support a legal stand-point on Act No 22’s doubtfully position as a proper healthcare Act and its transgressing of the Constitution.

The post-1994 Political-dispensation’s one-sided unscientific opinions and mal-thinking on healthcare practices, that had led to the justification of a so called “African Culture” that promotes specific the quackery traditional healing, makes the successfully outcome of an opposing public standpoint, like this one against Act No 22, minimal.

Conclusions

The Traditional Health Practitioners Act (ACT No 22, 2007) is an improper healthcare Act, a constitutional mishap. In light of its high level political sanctioning, it stands firm and it must be accepted that it will not be comprehensive revised, neither be repealed, in the next 10 to 20 years.

Further misuses of the Constitution with Act No 22 by the traditional healer fraternity, with more and stronger official sanctioning, can be expected.

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Conflict of interest

The authors do not have any financial or personal conflict to declare.

Declaration

All the information contained in this manuscript has not been presented elsewhere.
ADDENDUM A4:

PUBLISHED ARTICLE 4

(CHapter 7)

THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007): A GODSEND OR AN ACT THAT SPELLS DOOM FOR SOUTH AFRICA’S HEALTHCARE?


[Archives Australasian Medical Journal; Vol. 10 (2017), No. 3: The Traditional Health Practitioners Act No 22 (2007): A godsend or an act that spells doom for South Africa’s healthcare]
The Traditional Health Practitioners Act No 22 (2007): A godsend or an act that spells doom for South Africa’s healthcare?

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RESEARCH

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ABSTRACT

Background
South Africa’s development and growth in healthcare since the 1900s is phenomenal, but certain present-day healthcare policies such as the Traditional Health Practitioners Act (Act No 22, 2007), could jeopardize it.

Aims
The study aims to determine if the Traditional Health Practitioners Act No 22 is a godsend to the South African healthcare or if there is an indication of doom.

Methods
This is an exploratory and descriptive study that makes use of an historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as
primary sources to reflect on the thinking and opinions around the contribution of the Traditional Health Practitioners Act No 22 of 2007 to the South African healthcare sector. The findings are offered in narrative form.

**Results**

It seems that the Traditional Health Practitioners Act No 22 (2007) was promulgated without comprehensive exploratory research and an in-depth consultation with all the role-players involved in South Africa’s healthcare, especially the already statutory registered health professionals.

**Conclusion**

Political influences played a strong part in the promulgation of the Traditional Health Practitioners Act in 2007. In 2017 it is still not fully operational and the indication is that it will take years for the traditional health practitioner to become a full member of the health sector, if ever. This health Act can cause serious long-term disturbances for the already established healthcare practitioners and the statutory healthcare sector.

**Key Words**

Traditional healer, traditional health, traditional philosophy, pre-modern, medical mixtures, public health, statutory status

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**What this study adds:**

1. **What is known about this subject?**
   Very little research has been done on the possible effects of the Traditional Health Practitioners Act No 22 (2007) on South African healthcare.

2. **What new information is offered in this study?**
   The study suggests erroneous thinking and naivety among the legal draftsmen of the parliament regarding the devastating effect that Act No 22 (2007) can have on South African healthcare.

3. **What are the implications for research, policy, or practice?**
   A new, well-planned initiative to revise or even to recall the Traditional Health Practitioners Act No 22 (2007).

**Background**

South Africa’s healthcare system is supported by excellent laws that regulate its healthcare practitioners. These laws assure that the health practices, ethics and training of its practitioners are world class, and that the future development of the healthcare establishment and its services will at all times benefit South Africans.

The Traditional Health Practitioners Act No 22 (2007), with the sole aim of recognizing the traditional healer as a statutory health professional within the healthcare establishment, appears to reflect negative manifestations that could do the healthcare serious damage. The Act elicited controversy when it was first promulgated in 2003 because it was seen as pre-modern health legislation for a modern society. Furthermore, it was not well-research in respect of the need for traditional health, the negative effect that it could have on general healthcare or established health professions and other long-term consequences. Neither was its level and standards of training ever properly debated.1-6

**Method**

The research was done by means of a literature review. This method entails formulating a view based on the available research evidence. This approach is used in modern historical research where there is a lack of information on a topic. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for the period 1984 to 2014, articles from 1978 to 2016, books for the period 1990 to 2014 and governmental documents covering the period 1957 to 2015. These sources were probed to find out if the Traditional Health Act No 22 (2007) is a godsend or an act that spells doom for the South Africa’s Healthcare.

The findings are offered in narrative form.
Results

There are few fields within healthcare world-wide that elicits such controversy as traditional healthcare. South Africa’s traditional healthcare issue is therefore not an exception.

Much of the South African literature on traditional healthcare stretches over more than 50 years and offers various opinions, meanings, views, postulations, generalizations and myths about the good nature, excellent healing abilities, distinctiveness and indispensability of the traditional healer. These literature, for instance, states that between 60–95 per cent of all South Africans regularly consult traditional healers before consulting modern doctors and that there are 200,000 traditional healers in practice compared to 30,000 medical doctors. Traditional healers are cited as an important national health resource and the literature claims that there is at present a dramatic evolution in “traditional medicine”. It is further cited that patients prefer the holistic treatment approach of the traditional healer above an allopathic one. It is stated that 60 per cent of South African babies have been delivered by traditional attendants. The literature argues that the European/Western previous governments of South African have discriminated against indigenous healthcare, limiting its capacity. According to this argument, Apartheid and White supremacy led specifically to the underdevelopment of traditional healing in South Africa. 43

One-sided, superficial and unspecific research on traditional healing

An in-depth review of official and popular literature on South African traditional healing shows a very one-sided, superficial and unscientific research approach and reporting: one that is based most times on repeated quotations of old, and not always trustworthy, information. Explicit descriptions and analyses, based on sound and in-depth research of historical events and facts, reliable and well-reported statistics and other supportive evidence to enlighten the role of the traditional healer, are completely missing from most literature. 10–14

The unfounded claims of traditional healers that they act as a medium with the ancestral spirits; that they are able to interpret messages from the ancestors; that they can bring luck, fidelity, or make rainmaking; that through their distribution of muti around and about the kraal, they can ward off lightening or cause the witch discomfort in her bad endeavours; that they can with muti destroy the powers in other people and can have people contract fatal diseases; are seemingly all accepted by the propagandists and many reporting researchers (mostly well-trained Europeans and Westerners) as true and good personal and practitioner’s talents. 2

This point of view is maintained, notwithstanding the fact that it is false and in conflict with modern health therapy and treatment. It is also contrary to the Witchcraft Suppression Act (No 3 of 1957) as amended by Acts No 50 of 1970 and No 33 of 1997 of South Africa to combat the evil behaviour of the traditional healer. Mental impairment (especially the schizophrenic and the antisocial personality disorders), seemingly a major characteristic of the traditional healer, are accepted as normal. They are defined as essential parts of indigenous people’s culture. This view stretches a so-called “African Culture” of South Africa as real and correct to excuse abhorrent behaviour. Even the Traditional Health Practitioners Act No 22 (2007) defines the term traditional philosophy with the words “uses of traditional medicines communicated from ancestors to descendants” as a normal part of life and mental phenomenon to be accepted unquestioningly by all South Africans because it is a formal part of the Act. 44–50

Well-structured introduction plan for traditional health since 1969

The introduction and offering of the traditional healer to the general public of South Africa as a health practitioner has been well-structured and planned, especially since 1994. Political and emotional rhetoric about the traditional healer and his “unique medicine” as a victim of colonial powers, the South African Apartheid regime and the Western/European health fraternity, became standard remarks in speeches, articles and other publications. 1–4,28,33

Even the good name of various South African medical research bodies have been clouded over by the South African traditional healers and their misleading statements about their alleged distinctive role in the manufacturing and sales of so-called “traditional medicines”, or more specifically pre-modern medical products. General information, based on worldwide references, is falsified and used excessively and out of context for the South African scenario. 3

Compiling a trustworthy profile of the South African traditional healer and his medical products outside political and emotional rhetoric and other superficial literature like the above, is impossible. It is not possible to ascertain member numbers, levels of expertise, school and professional training, ethics, public needs and consultation ratios,
or the ratio between Western healers and traditional healers. If the above descriptions and superficial literature are used, we will only arrive at falsities, like many South African studies on traditional healing already reflect. To put traditional healing in perspective, the Traditional Health Practitioners Act No 22 (2007) must first be analysed and interpreted thoroughly as the starting point of research and discussion. Only after that can the assumptions, generalizations, deceptions and myths around it, be taken into account.\textsuperscript{5}

The post-1994 South African government, together with activists and propagandists of traditional healing, seem to have ensured that a multifaceted, multicultural and multi- cosmological context for health and mental healthcare delivery has come to pass; one that includes traditional healers, no matter the costs, risks and uncertainty that this entails. All legitimate objections against the traditional healer and the status of traditional healing as an official health service were ignored and trashed with a well- planned strategy, starting as early as the 1960s. The plan or strategy is clear, namely, to use the new democracy of South Africa as a vehicle to change remnants of the pre-1994 political, economical and social scenario, which included the establishment of a Western and European healthcare sector and the already regulated health professions\textsuperscript{10-13,23,51-62}.

This perspective seems to reflect the fast-tracked process to recognize the traditional practitioners statutorily with the Traditional Health Practitioners Act (Act No 22, 2007). There were precautions to avoid pitfalls. In connection with the above, it must be remembered that the hay-day of the political emancipation, that started in 1969 with the National Democratic Revolution (NDR) of the ANC, was aimed at establishing a considerable degree of self- determination by indigenous South Africans, whether applicable or not. The postulation then was that health services should be based on a mixed socialist-capitalist economy and a socialized or nationalized form of healthcare services, open for service delivery to all. Internal inputs to the new health plan were led by the National Health Committee of the ANC, the United Democratic Front (UDF) and its affiliate, the National Alternative Medical and Dental Association (NAMDA), NEHAWU, the Inkatha Freedom Party (IFP), the National Progressive Primary Health Care Network (NPPHCN) and Doctors for Life (DFL) International. Very little has changed since then on this 1969 revolution master plan, nor has there been any consideration of its possible negative consequences.\textsuperscript{110-13,17,20,23,60,63,64}

The ANC stated again in 1994 in its Health Plan, without offering any sound argumentation or facts, that indigenous cultural preferences, like traditional healing, would become an integral and recognized part of healthcare in South Africa. The basic view is that the consumer must have the right to choose a health practitioner, notwithstanding whether that health practitioner is the best for him or her or society as a whole in terms of training, risk, safety and know-how. To reach this objective, the ANC aimed to change health legislation to facilitate the controlled use of the traditional healer, but at the same time to take total charge of the entire healthcare and its already regulated practitioners in South Africa.\textsuperscript{10-13,31,60}

Foreign role players in the promotion of traditional healers in South Africa were the African Union (AU), which, with its declaration in 2001 of the \textit{Decade of African Traditional Medicine}, acknowledged the role played by traditional “medicine” and the need to integrate it into national health systems of African countries. The same is valid for the World Health Organization (WHO), with its 1978 \textit{Alma-Ata Declaration of Primary Health Care}, when it recognized and endorsed traditional “medicine”. This was followed by its \textit{Traditional Medicine Strategy 2002 to 2005} and various other WHO guidelines, which all emphasized the integration of traditional health into national healthcare in Africa.\textsuperscript{31,39-42,54,65-71}

A massive infiltration into South Africa’s governmental law- making and executing agencies by traditional healers and their co-agents, is also evident.\textsuperscript{72} A good example of this in- depth infiltration was the remark in 2013 by the then Deputy Minister of Health when she stated that it is the government’s goal to integrate Traditional Health Medicine into the National Health System as soon as possible. She also made known that many primary healthcare facilities and hospitals are already working with traditional health practitioners with governmental approval to contain childhood diseases like diarrhea and vomiting, HIV/AIDS and TB, mental illness and many others, as well that many traditional health practitioners sit on clinic committees, hospital boards, district health committees and provincial and national advisory structures.\textsuperscript{71}

Objection and resistance to the Traditional Health Practitioners Act No 22 (2007) were minimal and unimpressive. The fact that the Traditional Practitioners Bill of 2003 passed through Parliament without a single objection or formal protest from a parliamentarian (either by the ANC as the ruler and the DA as the opposition), reflects the extreme and comprehensive emotional, political and cultural domination and drive to promulgate the Act at that

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time. The lack of objection was notwithstanding the fact that all the parliamentarians should have had knowledge of the future high costs to implement the Act, its lack of sound training, its negative effect on the health sector and the already regulated health professionals, as well as the fact that it would take years to organize the traditional healers’ unorganized and undisciplined system.\textsuperscript{5,74}

**Discussion**

The main issue for the post-1994 government has been the balancing act between sensitive “African” beliefs and customs, which were widespread among its loyal voters and supporters (however illogical, outdated and unscientific in comparison to modern scientific thinking, practice and facts it may have been) and a more westernized approach. The support from the more traditional citizens led to the enactment of laws, not always successfully, to manage “African tradition” by way of the legal system and to cope specifically with the problem of diversity among its people, including both the developed and undeveloped sectors. The Traditional Health Practitioners Act No 22 (2007) is such a legal outcome.\textsuperscript{75}

This also reflects, inside this “African tradition”, the beginning of a new, post-1994 policy of political correctness, notwithstanding its hypocrisy and detriment to the individual’s constitutional rights. This new policy replaced the old, pre-1994 suppressing policy of the Apartheid regime very successfully. This means the continuation of a policy of no tolerance of any criticism by the so-called democratic, post-1994 government on their decisions, legislations, opinions and doings. This lack of opposition includes all the governmental, semi-governmental agencies and non-governmental organizations. It seems to be only the Treatment Action Campaign (TAC) that has not warmed up to traditional healing as a formal medicine partner in the health sector. The DFL (although an initial role player in the establishment of the Traditional Health Practitioner’s Act), did resist it in a court case, but they focused more on legal protocol.\textsuperscript{1,4,23,54,59}

Up to this point, the general view has been that the official opposition in Parliament seems only to be focused on the impact that the Witchcraft Suppression Act No 3 (1957) can have on the constitutional rights of pagans, their religious and cultural beliefs, and the illegal identification of persons as witches and witch-hunting crimes, instead of focusing on the primary negative impact of the Traditional Health Practitioners Act No 22 (2007) on public health and discipline.\textsuperscript{60}

**Strength and limitations**

The research highlighted the erroneous thinking and arguments of propagandists, activists and politicians in South Africa involved in the promulgation of a pre-modern health act and the statutory recognition of an oracle as a health practitioner.

This research does not fit in with the mind-sets of present-day believers in traditional healing in South Africa. In their under-writing of the post-1994 policy of political correctness, it will be ignored.

**Conclusion**

The new crippling, dominating and devouring influences of the post-1994 cultural–political setup of South Africa on its existing modern establishments, like healthcare (which the neo-1994 political activists allege purely developed out of colonial and Apartheid regimes and which they see as still sustained by the post-1994 political set-up), led thereto that many people in public life are remaining quiet about the traditional healer as a new regulated health service partner. This includes people in healthcare, in academia and journalism, not only because they want to be politically correct, but also to stay out of conflict with or victimization by the present regime. They refrain completely from any criticism or even an opinion on health, religious, cultural, indigenous and political phenomena. A curtain of “silence” has been drawn and the rights of the minority became subdue to that of the majority.\textsuperscript{5,60,62,76–88}

It is therefore no surprise that the Traditional Health Practitioners Act No 22 (2007) has become a very dominating pivot, encircled by opportunistic, emotional and political agenda, false cultural distinctiveness and pseudo neo-African (but many times aged and outdated African) intentions. It is projected as the \textit{saviour} of the traditional healer and his indigenous culture and the \textit{solver} of the health problems of South Africa’s poor people.\textsuperscript{5}

Seeing that the Traditional Health Practitioners Act No 22 (2007) occupied over 11 years of formal parliamentarian plodding to reach promulgation, but is still not fully operational in 2017, it is doubtful that it has a solid enough
legal foundation, empowerment and focus to obtain true statutory status for the traditional health practitioner in the future. It is also doubtful if the traditional healer is equipped (in terms of education, training and skills) to be made a successful full member of the health sector.

This doubt is confirmed by the intended Regulation No 1052 (2015) that aims to give some guidelines as to how the Traditional Health Practitioners Act No 22 (2007) can get a seat in the healthcare sector. The wariness since 1994 by the government not to repeal the Witchcraft Suppression Act (No 3 of 1957, as amended), seems a further indication of doubt regarding the desirability of the traditional healer as a professional health practitioner and possible fear that the traditional healer’s practice can get out of control inside the established healthcare sector and its services.⁵,⁸⁹

Two opposing research questions are reflected by this research. Is the Traditional Health Practitioners Act of 2007 a godsend for South Africa? Versus: Is the Traditional Health Practitioner Act an act that brings doom for South Africa’s healthcare?

From this study, it is justified to conclude that the Traditional Health Practitioners Act No 22 (2007) spells doom for South African healthcare. The evidence is that it does not have a place in the honourable collection of South African health laws.

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THE PRESENT AND FUTURE ROLES OF TRADITIONAL HEALTH PRACTITIONERS WITHIN THE FORMAL HEALTHCARE SECTOR OF SOUTH AFRICA, AS GUIDED BY THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007)


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The present and future roles of Traditional Health Practitioners within the formal healthcare sector of South Africa, as guided by the Traditional Health Practitioners Act No 22 (2007)

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RESEARCH

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ABSTRACT

Background
The promulgation of the Traditional Health Practitioners Act No 22 (2007) was seen as the long awaited start-up of the traditional healing profession in South Africa. Act No 22 (2007) was strongly politically driven from the late 1960s onward. Many of these political motivators were based upon outdated cultural ideas, customs and traditions, rooted outside the modern day healthcare needs and demands of the particular population that traditional healing intends to serve.

An in-depth needs and skills analysis, to test the viability and sustainability of the South African traditional healers as well as their positions and roles as health practitioners inside the formal healthcare sector, as guided and stipulated by the Traditional Health Practitioners Act No 22 (2007), was lacking in this early development and start-up process. This resulted in the traditional healers’ present and future roles as specific healthcare practitioners being both undefined and insufficiently formulated. In addition their existing education, training, skills and abilities to compete in the formal healthcare sector were ignored. Therefore, since the promulgation of the Act in 2007, there was limited profession development for traditional healers, to improve their immediate professionalism and thus to promote effective role-playing and management in the formal healthcare sector.
The South African traditional healing professional model is still in the foundational stage of its professional development; a stage which the other registered/regulated healthcare practitioners of the country surpassed long ago, making them well-equipped for role-playing and management as health professionals in the formal healthcare sector. The whole venture of the statutory recognition of the traditional health practitioners in 2007 as new healthcare professionals with the promulgation of the Traditional Health Practitioners Act No 22 (2007) seems to increasingly be a failure. There is thus a definite need to establish how the South African traditional healers are equipped to compete independently in the healthcare sector. If this is not possible, what alternatives are available to steer some of them into the country’s healthcare sector and still make them useful as health practitioners. Coupled to this need is the future status and role of the Traditional Health Practitioners Act No 22 (2007), to uphold the roles of traditional healers.

Aims

The study aims to determine the present and future roles of the traditional health practitioner in the South African formal healthcare sector, as guided by the Traditional Health Practitioners Act No 22 (2007).

Methods

This is an exploratory and descriptive study that makes use of a historical approach by means of investigation and a literature review. The emphasis is upon using current documentation such as articles, books and newspapers as primary sources to reflect upon the present and future roles of traditional health practitioners within the regulated healthcare sector of South Africa, as guided by the Traditional Health Practitioners Act No 22 (2007). The findings are offered in narrative form.

Results

It seems as though the professional position and foundation of the Traditional Health Practitioners Act No 22 (2007) is on a level that is meant for the governing of a healthcare group with a well-established learning and management infrastructure. This is an unfortunate situation wherein the incoming traditional healer unfortunately cannot meet the requirements at the moment. Various negative factors have affected the South African traditional healers’ development and position. These include early political out-casting and discrimination from training facilities and work opportunities in the healthcare sector under White Rule, while poor organization, strategy and future planning and a lack of self-promotion by traditional healers themselves regarding their positions and roles over the years, seem also to have contributed negatively to the situation.

The immediate impact is that this predisposition unfortunately places the traditional health practitioners in situations wherein they cannot always take specific roles at present or in the future as healers in the South African healthcare sector, as intended and guided by the Traditional Health Practitioners Act No 22 of 2007.

Conclusion

To expect the South African traditional health practitioners to function at present and in future fully within the intentions of the Traditional Health Practitioners Act No 22 (2007), executing certain roles as independent health practitioners in the formal healthcare sector, seems to a great extent impossible. Wherever they are successfully placed in the healthcare sector, their positions and roles seem to be limited.

Furthermore, the traditional healers’ places in the formal healthcare sector were already taken by the allied health professions, by such practitioners as homeopaths, naturopaths and ethno-therapists, etc. Thus they are obliged to compete with the already established nursing practitioners, psychiatrists and psychologists, as well as medical doctors, all established in clearly defined and functioning roles. These work inclinations and reservations further minimize their roles dramatically in the formal healthcare sector.

To consider the future of the Traditional Health Practitioners Act No 22 (2007) and its two outcomes, namely the Traditional Health Practitioners Council as well as the traditional health practitioner, there are at present three urgent issues. The prominent question is: can the Traditional Health Practitioners Act No 22 (2007) continue in its present form or must it be recalled? In its present manifestation the Act and the traditional healers seem to be ineffective and aimless.

It is time to consider alternatives to assure the continuation of the traditional healers as practitioners in the South African healthcare sector. The most obvious and practical one is to accommodate some of the traditional healers,
where applicable and possible, in some of the various already established professional Health Councils as healthcare professionals.

**Key Words**
Afterlife, ancestor, customs, gods, healthcare, pre-modern, professionalism, spirits, tradition

**What this study adds:**

1. **What is known about this subject?**

There is a lack of research on how the traditional health practitioners really fit into the present or the future formal healthcare sector of the country.

2. **What new information is offered in this study?**

The information provided highlights that the traditional health practitioners are already experiencing difficulty with playing a role in the present healthcare setup; there is the potential for many more problems in the future.

3. **What are the implications for research, policy, or practice?**

The traditional healers as a group seem to fail to activate and steer Act No 22 (2007), in order to upgrade themselves and to take on certain independent roles as health professionals in the South African healthcare sector.

**Background**

The promulgation of the Traditional Health Practitioners Act No 22 was welcomed in 2007 as the ultimate solution to the traditional healers’ insecure and undefined position as healthcare practitioners in the South African formal healthcare sector. Through the implementation of the various resolutions of the Act it was believed that the newly created health professional, namely the *traditional health practitioner*, would obtain the necessary recognition to take on various independent roles within the country’s healthcare.

There seem to be public and political beliefs that the traditional healer is a unique, extraordinary and distinctive type of health practitioner; a special person with secret health training and treatment know-how that he or she inherits or receives from ancestors, spirits and gods. After their graduation as traditional healers, they are seen by some people in South Africa, who believe in traditional healing, as half-man and half-spirit. It is professed that his/her input is of high medical value to the healthcare of the country, especially in the poor areas. This was one of the strong arguments to get the traditional healers statutorily recognised as healthcare professionals, and Act No 22 (2007) was promulgated to steer this medical recognition effectively.

This mind-set on the traditional healers’ abilities is well reflected by the definition of *traditional philosophy* of the Traditional Health Practitioners Act No 22 (2007), as well as the Act’s described intentions to proclaim traditional healing as a total and unique healthcare fraternity within the established South African healthcare sector.

These abilities and skills of the traditional health practitioners would seem to have made them capable to take on positions and to play specific roles as independent health professionals in the present and future formal healthcare sector.

This view is well illustrated in Figure 1 in which the central position of the traditional health practitioners, favoured by the intentions of the Traditional Health Practitioners Act No 22 (2007) and by specific planning of the government in terms of this Act, are clearly highlighted.

The aim of this study was to determine the present and future roles of traditional health practitioners within the formal healthcare sector of South Africa, as stipulated and guided by the Traditional Health Practitioners Act No 22 (2007).

**Method**

The research was carried out by means of a literature review. This method entails formulating a view based upon the evidence presented in the literature. This approach is used in modern historical research centering upon topics about which there is little information. The databases used were EBSCOHost, Sabinet online and various contemporary sources such as newspapers and reports for the period 2006 to 2016, articles from 1992 to 2016,
books for the period 1990 to 2013 and government documents for the period 1974 to 2016. These sources were consulted in order to offer a view upon the present and future roles of traditional health practitioners within the regulated healthcare sector of South Africa, as guided by the Traditional Health Practitioners Act No 22 (2007).23,24

The findings are offered in narrative form.

Results

The Traditional Health Practitioners Act No 22 (2007), a legal entity as a vehicle to raise the professional identity and status of traditional healers in the South African Society, clearly overshadowed the traditional healing leadership thinking on what the traditional healers can and may do versus what they cannot or may not do in practice, in terms of their specific abilities and skills, as well as their public’s needs. This one-sided leadership thinking and belief, together with the traditional healers’ much acclaimed uniqueness to be equipped to take on many and various roles in the formal healthcare sector, left them unprepared for the fact that they had to compete with other healthcare professionals, already established in the formal healthcare sector. To continue old roles and to take on new roles through the implementation of the resolutions of the Act thus required a new, in-depth understanding of the formal healthcare environment, its various role-players and pre-requisites prescribed in terms of training and practitioners’ rights, etc. The political influence and driving of the traditional healers as a group since the 1960s, especially from 1997 onward in the post-Apartheid dispensation advancing Black Empowerment, made them further opportunistic about future roles in terms of promises on their new political and cultural rights in the New South Africa.1–9

The traditional healers had specific roles that they thought they could and would be able to execute with their statutory recognition in 2007. However, these roles were clearly limited, and even blocked for them, as a result of their poor health training and the standards on the one hand which Act No 22 failed to generate. On the other hand, awaiting them were two dominant health groups as strong competitors, well-established in the formal healthcare sector, namely the allied (alternative) and the allopathic fraternities.14–16,19,20

Figure 121,22 confirms that the compilers of the Traditional Health Practitioners Act No 22 (2007) and the traditional healers themselves never studied in detail the present day existence of the allied and the allopathic healthcare fraternities of South Africa, before the Act was initiated in 2003. The allied health group’s in-depth foundation and position in traditional healing in South Africa, established over many years, as an opposition to the new traditional health practitioners created by the Traditional Health Practitioners Act No 22 (2007), was especially bluntly and blindly ignored.1–3,5,6,8,27–29

It is clear that with the acceptance of the Traditional Health Practitioners Act No 22 four years later in 2007, as a legal institution and safe-house for the traditional health practitioners, the government failed completely to acknowledge particularly the unique identities and roles in South African traditional healing of the various established allied health practitioners, such as the homeopaths, naturopaths, phytotherapists and ethno-therapists as similar but opposing healthcare providers to the traditional health practitioners. This ignoring of the traditional healers was also evident in the already established practice education and training-cultures of the allied traditional healthcare and medicine, as specifically represented by the already regulated ethno-therapists, phytotherapists, homeopaths and naturopaths. This negative outcome is also unmistakable in the South African post-1994 government’s and some of its leaders’ dislikes for European/Western and pre-1994 health models and systems, as well as their open dissatisfaction and revenge, because the allied health professions had since the 1970s firmly closed their doors for the pre-modern South African traditional healers to be registered with them, even as ethno-medicine practitioners. This door was already closed by the allopathic group on the South African traditional healers in the 1960s.1–3,5,6,8,27–29

The allopathic dominance of South African healthcare since 1652

It is increasingly clear that the education tripartite unity that is an absolute pre-requisite before professional status can be awarded to a healthcare group to be allocated roles or responsibilities, is totally absent from traditional healing in South Africa. Not even the Traditional Health Practitioners Act No 22 (2007) and its struggling governing body, the Traditional Health Practitioners Council (THPCSA), could rectify the situation since 2007. This means that a successive empowerment through education and learning, diagnosis and treatment, ending in a scope of
practice to take on roles in the formal healthcare sector, has never formally developed in South African traditional healthcare.30-33

The medical fraternity, with specific reference to medical doctors and dentists, established itself successfully over the years out of the European traditional medicines and practices, as established in 1652 at the Cape of Good Hope. An initial competitor was certainly indigenous traditional practices and medicines. However, given that this was scattered across the country and practiced in a limited manner by certain tribes, and was spiritually orientated, it failed to develop scientifically and to become a role-player in the mainstream of healthcare development. Thus that threat was erased. Therefore the medical and dental practitioners became the holders and bearers of the holy medical grails in South Africa over the years. World War II gave a new dimension and empowerment to medical development and skills. This well-established fraternity was soon enlarged with various new, well-trained allopathic healers such as physiotherapists and psychologists, as well as the allied healers who took over all the possible traditional healthcare manifestations. This important outcome, which missed the attention of many South African researchers who investigated traditional healing, closed the door forever on the traditional healers for a partnership in present-day formal healthcare; something which the Traditional Health Practitioners Act No 22 (2007) has been trying since 2007 to revive at all costs.8,16,21,34

The allied-traditional health fraternity’s current statutory recognition in South Africa

The well-established allied-traditional health professions of South Africa were ignored by the compilers of the Traditional Health Practitioners Act No 22 (2007). In the 1970s these professions began, with the exception of the traditional healers who had remained passive and undeveloped since 1652, to position themselves strongly in the formal South African healthcare sector in terms of training and education against serious opposition by the Apartheid Regime and the medical fraternity of that time. In 1982 they obtained ultimate statutory status with the Allied Health Practitioners Act No 63 of 1982. Today the allied group consists of 13 disciplines, namely Ayurveda, Chinese medicine, acupuncture, chiropractic, homeopathy, naturopathy, osteopathy, phytotherapy, therapeutic aromatherapy, therapeutic massage therapy, therapeutic reflexology and Unani-Tibb. Chiropractic and Homeopathic training are offered by full-time Masters degrees at the University of Johannesburg (UJ), and the Durban University of Technology (DUT), while Naturopathy and Phytotherapy are offered by the University of the Western Cape (UWC) with three years of training in basic medical sciences and a further two years of specialization in the applicable discipline.21,35–39

Chaotic planning of present and future traditional healthcare

Heretofore the traditional healers had stayed out of any health development since 1652 in South Africa, and when invited, withdrew from participation with the other allied professions in obtaining regulation or to better themselves. opportunistic politicians, are still naively anchored in the anthropology and philanthropic thinking on African cultural lifestyles of the past. The need for their service is also distorted in the process as essential. Through this pathway these propagandists and believers are trying to recreate a domain for the traditional healers in the formal healthcare sector of South Africa, notwithstanding the strong opposing healthcare inclinations and intentions of the Traditional Health Practitioners Act No 22 (2007) to their outdated thinking as well as the assimilation of traditional healing into the professions of homeopathy, naturopathy and phytotherapy, as activated by the Allied Health Professions 1–22.

They failed, to a certain extent, by their own actions and background, to develop a health science, a learning culture and a professional practice and ethics, as the allied health professions had successfully done. Instead, the traditional healers lingered on with a spiritual and doubtful practice; one without any real medical or healthcare training or scientific principles and methods.1–4,35,36,38,43

They have remained in disarray since 1652 with the establishment of the Cape of Good Hope Settlement in a pre-modern health training and practice setup. This is well illustrated by the following self-description of a South African traditional healer: “Many traditional medical practitioners are people without education, who have rather received knowledge of medical plants and their effects upon the human body from their forebears.” 17,par 1

The end result clearly indicates why the traditional healers of South Africa were totally ousted in the 1980s as a partner from the allied health fraternity, basically because of their pre-modern inclinations to medical products,
training, diagnosis and treatment, hence their under par position of not being able to register as allied health practitioners. Despite how much South African politicians and propagandists of traditional healing opposed and discarded this outcome, the fact is that the traditional healers’ positions, roles, training and identification as health practitioners were overtaken in time in South Africa by the allied-traditional healers, specifically the homeopaths, naturopaths and phyotherapists. This gradual incorporation became official and final in terms of the Allied Health Professions Act No 63 (1982). 17,34

This phasing out of traditional healing, a remnant of the old tribal culture of South Africa is a reality which propagandists and believers of traditional healing do not fully understand or want to admit today. Here in South Africa the thinking and belief on healthcare models for indigenous people of these propagandists and believers, strongly supported by Act No 63 in 1982.

The chaotic planning on traditional healthcare in South Africa is undoubtedly further aggravated by the outdated opinions, viewpoints and influences of outsiders who are not only unfamiliar with the South African healthcare scenario, but are opposing formal healthcare education, training and standards for the traditional healers, seemingly in an exclusive effort to revive colonial thinking on so called “good” healthcare delivery and services upon behalf of indigenous people. This stereotypical and subjective thinking blindly ignores the modernisation and upliftment of the living standards, accompanied by enormous changes in personal, economic, social and especially healthcare needs and preferences of the greater South African population since the 1990s, which has in practice nullified the need for pre-modern traditional healing. 1-22

The present-day chaos in planning of the South African traditional healing must be addressed urgently. There are first level remedies available.

**There may still be time to place some traditional healers within the established statutory health professions**

The traditional healer’s position as an independent health practitioner in terms of the Traditional Health Practitioners Act No 22 (2007) seems to increasingly be unacceptable in terms of various healthcare criteria, nor viable or sustainable in South Africa as an independent healthcare profession. On the other hand, there is at present still a possible place for some of the traditional healers such as the herbalists group within the allied health group, as well as for some of the other traditional healers such as diviners and birth attendants in the other health groups. As a result of their diversity in training, education, practice styles and healthcare beliefs it is impossible to categorise them into a single, uniform group to be considered for assimilation into the established healthcare groups. Selection can clearly only be carried out on the principle that individuals may be incorporated into these established health groups. This, on the other hand, can only happen if the traditional healers fulfil a minimum level of formal education and training, to enable them to be trained on a tertiary and professional level within these various groups’ professional requirements and to reflect the skills and abilities for patient safety services.

Traditional healers must thus, but only as individuals, be re-directed immediately. As a point of departure it must be considered to repeal the Traditional Health Practitioners Act No 22 (2007) and to phase out the Interim Traditional Health Practitioners Council as a governing body. The fact that both, although introduced in 2007 to professionalise and progress traditional healing, are today still in a passive gear of performance and the formal registration of the traditional health practitioners is still under par, makes such an intervention at this stage both possible and easy. The failure of the traditional health practitioners, notwithstanding the Traditional Health Practitioners Act No 22 (2007)’s legal driving of the process and the direct political support from government bodies, to move successfully since 2007 into the formal healthcare sector of South Africa, to take on specific roles independently from the other healthcare professions, to mobilise an expected group of clients to be viable and sustainable as a specific healthcare practitioner and to create a formal learning and training culture, puts the continuation of the traditional health practitioners as a present and future role-player in the healthcare sector in jeopardy. 8,21,22,34,39,44-50

With reference to the unregulated alleged 200 000 and more traditional healers as a group, most of them must be left unregulated as in the past. In this respect it must be noted that from strict criteria used, it seems that not more than 4 400 of these traditional healers qualified in some way to be become registered in terms of the Traditional Health Practitioners Act No 22 (2007). This means that if a strict selection is being made between so called charlatans, bogus, bona fide and “real” traditional healers in South Africa, very few of the alleged 200,000 traditional healers will reach the end-mark to be registered in terms of Act No 22 (2007). It is these potential
candidates that must be considered for possible registration with the already established healthcare councils.8,21,22,34,39,64–50

Individuals from this selective group of traditional healers such as herbalists can be moved into the homeopathy, ethno-medicine, naturopathy or phytotherapy disciplines of the Allied Health Practitioners Council. Individuals from the diviners can be moved into three possible areas, namely as psycho-counsellors to the Health Professions Council, as social counsellors to the Council for Social Welfare Sciences and some can be homed with old African church groups as priests or spiritual caregivers. Individuals from the grouping of birth attendants can be moved into the Nursing Council as assistant midwives. It seems that only the so called traditional surgeon may be problematic to accommodate into the established healthcare councils, basically due to their history of risks to healthcare.

With the above approach, the Traditional Health Practitioners Act No 22 (2007), the Traditional Health Practitioners Council (THPCSA) as well as the traditional health practitioners will automatically lose their central position and disappear from the South African formal healthcare scene if Act No 22 (2007) is not swiftly repealed.

The aforementioned suggestions are reflected in Figure 2.8,21,22

Discussion

The traditional healers were at some point in the past part of the allied fraternity, but lost their healthcare standing in the greater South African healthcare context due to their pre-modern and unprofessional training and practices. Their passivity to develop was also a negative determinant. Real traditional healing and traditional medicine, such as ethno-medicine and phyto-medicine, are now fully part of the already regulated homeopaths, naturopaths and phytotherapists’ practices and medicine.8,21

The South African traditional health practitioners, with their so-called African cultural uniqueness, forced in by the Traditional Health Practitioners Act No 22 (2007), have clearly been driven by its political intentions under a cultural mask since 2007. Their idolisation as a unique healthcare practitioner was a further driver. They are unwinvited partners in the modern-day healthcare sector of South Africa. They find themselves for good reason in a healthcare “no-man’s land”, as a direct result of the inapplicability of the Traditional Health Practitioners Act No 22 (2007) upon the healthcare environment. In addition the phasing-out of the traditional healers’ entity and identity as healthcare practitioners, by their own actions as well as external influences over many years, further exacerbated the situation. At present they are not only overstepping the practice rights of the current existing regulated health practitioners of real traditional medicine, but are, as health practitioners, within the established healthcare sector, not professional or financially viable or sustainable in this present identity. Furthermore, there are life risks for the public with their pre-modern products and treatment.

Strength and limitations

The study brings to the foreground the shortcomings of the South African traditional healers to take on specific roles as healthcare practitioners in the present as well as the future formal healthcare sector of South Africa.

The one-sided favouring and idolisation by the authorities and a segment of the public in South Africa of the traditional healers will limit this study’s impact.

Conclusion

The Traditional Health Practitioners Act No 22 (2007) is not healthcare friendly to the broad public, nor friendly to the traditional health practitioners that it created. The odds are against the traditional health practitioners, as evidenced by their history and their under par healthcare training, skills and abilities, to secure and uphold specific roles in the present and future formal healthcare sector of South Africa within the legal empowerment of Act No 22 (2007).

The truth is that the traditional health practitioners cannot be re-introduced as independent healthcare practitioners in the present and future formal health sector of South Africa. In their present form they are “Rip van Winkels”, 300 years too late for any roles.

Alternatives, completely removed from the Traditional Health Practitioners Act No 22 (2007) and its governing body, the Traditional Health Practitioners Council (THPCSA), must urgently be found to accommodate skilled and able traditional healers in the present and future formal healthcare sector of South Africa. Direct assimilation
into the various established and functioning healthcare governing-bodies seems to be the most obvious. This option must be considered.

Good decisions are sometimes hard to take, but are worthwhile in the end.

References


PEER REVIEW
Not commissioned. Externally peer reviewed.

CONFLICTS OF INTEREST
The authors declare that they have no competing interests.

FUNDING
None
Figure 1: The present-day regulation of healthcare practitioners in South Africa
Derived: Caldis\textsuperscript{21}, p. 2; Gqaleni et al\textsuperscript{22}, p. 177

Figure 2: Corrected future regulation of healthcare practitioners in South Africa
Derived: Caldis,\textsuperscript{21} p. 2; Gqaleni et al,\textsuperscript{22} p. 177
ADDENDUMS B1 TO B14:

REFERENCE-FOCUSSED ARTICLES

(Articles 6 to 19)
ADDENDUM B1:

PUBLISHED ARTICLE 6

(CHapter 2)

ARE THERE 200,000 AND MORE TRADITIONAL HEALERS PRACTICING IN SOUTH AFRICA?


[Archives Australasian Medical Journal; Vol. 9 (2016), No. 12: Are there 200,000 and more traditional healers practicing in South Africa?]
Are there 200,000 and more traditional healers practicing in South Africa?

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ABSTRACT

Background

The promulgation of the Traditional Health Practitioners Act No 22 (2007) was guided to a great extent by the allegation that there were 200,000 and more traditional healers practicing in South Africa. This number had also reflected a great demand for their services. Regulation was thus in the early 2000s an immediate need to safeguard the public against malpractice of these practitioners.

Aims

The aim of this study is to determine if the allegation that there are 200,000 and more traditional healers practicing in South Africa is true.

Methods

This is an exploratory and descriptive study that makes use of an historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on the thinking and opinions around the numbers of traditional health practitioners in South Africa. Findings are represented in narrative form.
Results

The Traditional Health Practitioners Act No 22 (2007) was promulgated without applicable and appropriate needs analysis of traditional healers as healthcare practitioners by the public. The true number of traditional healers, to make it a viable and sustainable healthcare profession in South Africa, was never determined. The alleged number of 200,000 and more traditional healers was the untested motivator for the promulgation of the Act in 2007.

Conclusion

The allegation that there are 200,000 and more traditional healers practicing in South Africa could not be confirmed. The true number of bona fide traditional healers in present-day South Africa seems insignificant.

It is of great importance that the official registration process of the South African traditional health practitioners is fully activated in 2017. Only then will clearance on the real number of traditional healers practicing in the country be obtained and can constructive decisions on the group’s future be taken.

Key Words

Assumption, bogus, bona fide, membership, tertiary, unofficial, unregulated

What this study adds:

1. What is known about this subject?

The true presence of traditional healers in South Africa is under-researched and led to a lack of substantiated facts on it.

2. What new information is offered in this study?

This study presented evidence that the number of traditional healers is over-estimated and misleading.

3. What are the implications for research, policy, or practice?

The research-outcomes make the reason for the promulgation of Act No 22 (2007) and the statutory recognition of the traditional healer as a health practitioner questionable.

Background

The promulgation of the Traditional Health Practitioners Act No 22 (2007), which led to the statutory recognition of the traditional healers as traditional health practitioners in the South African health establishment, was based on and driven by various allegations, assumptions, thoughts, generalizations, statistics and other cultural and political information.

One of these motivators in the post-1994 new South African political dispensation was the chief allegation that there were at least 200,000 unregistered traditional healers practising in South Africa and who needed to be regulated. It was also alleged, in relation to these numbers, that there is a great need for traditional healers by the public. These views on the traditional healers are still today reflected in South African literature.1-7

For the various healthcare providers, like the psychologists, nursing practitioners and the medical doctors particular, these new health practitioners, consisting of an alleged 200,000 and more in numbers, are also important as a possible healthcare competitor, while for the medical funds and schemes as well as the employers this newcomer means an extra financial burden.

Method

The research was done by means of a literature review. This method entails formulating a view base about which there is little information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like news papers and reports for the period 1988 to 2016, articles from 1994 to 2014, books for the period 1990 to 2014 and government documents for the period 2007. These sources were consulted to reflect not only on the thinking, viewpoints and opinions of the present numbers of traditional health practitioners in South Africa, but also to obtain a future view on their numbers. The findings are offered in narrative form.8,9
Results

The popular mid-1980s number of 200,000 and more traditional healers in South Africa

Nowadays reports state the number of traditional healers in South Africa is at least as 200,000, with some researchers put it even so high as 400,000. Research shows that this general outcome of 200,000 is seemingly based on mid-1980’s publications, that on their turn was seemingly based on a 1983-estimation by the World Health Organization (WHO). No confirmation was or is obtained by researchers to confirm if the 200,000 outcome for South Africa is true, neither was research findings upgraded over the years with new data. 1-7

The present, popular data quoted in research on the numbers of traditional healers can clearly not be used to make a precise decision if the 200,000 is correct or incorrect. This unclearness needs further research and reviewing.

Membership of the Societies for Traditional Healers

One possible guideline to determine the true number of traditional healers in South Africa is the membership-count by traditional healer’s societies. This seems again problematic because there is not a single non-compulsory body to register all the so-called traditional healers as a single group. Further registration is in terms of an official registration with the statutory body for traditional healers, namely the Traditional Health Practitioners Council of South Africa (THPCSA), at the moment not compulsory. Compulsory registration in terms of the Traditional Health Practitioners Act No 22 (2007) was only started in 2016. 10,11

Many of the traditional healers are organized and “licensed” at the moment in South Africa by more than 200 unofficial organizations or associations; organizations themselves that are sometimes only officially registered under the Companies Act as a business unity but not as a professional body. Depending on the strength and criteria, membership of organizations range from 10 to 1,000, with some traditional healers based regionally, provincially or nationally. 10,11

The Traditional Healer’s Organization (THO) reflects 29,000 members, the Traditional Healers of South Africa (THSA) boasts about 350,000 members, while the national organizer of the THO estimates that there are about 183,000 traditional healers practising in South Africa. Hereto researchers quoted 185,477 to 400,000 traditional healers in South Africa. 6,13-16

Statements, based on membership numbers, can clearly thus also not unconditionally be accepted as correct, for various reasons as researchers warn. 11,17 The African Technology Policy Studies (ATPS) 17, p.30 reports: “It must be noted that certificates are not awarded on the basis of competence and there is no thorough scrutiny on the credentials of the individual before being awarded a certificate. This is simply done to increase the membership of the association to sustain it through the fees that is paid for registration and annual subscription”. This registration policy has resulted that many bogus traditional healers had obtained healer status and contribute to the 200,000 and more count. 11,17

Pretorius 11,par.5, in referring to the 200,000 alleged traditional healers in South Africa and the alleged population ratio versus traditional healers of 1:200, writes: “This apparently favourable ratio could, however, be deceptive, if the type and quality of care in the traditional sector is not taken into account. In the current economic climate and amid the concomitant unemployment, there is a market increase in the ranks of traditional healers, among whom there are, unfortunately, quite a number of charlatans. It is calculated that of the 80,000 persons practicing traditional healing in Gauteng, only about 10 per cent are bona fide healers”.

This means, if the alleged 200,000 number is true, at most only 20,000 qualify to be “real” traditional healers in terms of the Pretorius-criteria. 11 Regarding the 200,000 alleged traditional healers, the ATPS 17 emphasizes further that in the era of HIV/AIDS and other hard to cure diseases, the bogus practice of traditional healing is taken advantage of for the purposes of self-enrichment by people who are not at all “real” traditional healers. Further it seems that there is a contingent of bogus healers from East and West Africa who are counted into the assumed 200,000 South African traditional healers. Even the adjusted number of 20,000 as possible bona fide healers seems to be uncorrected and an over-estimate. 11,17
The various contamination names for the traditional healer are count-misleading

A further contamination factor in the determining of the present numbers of traditional healers in South Africa is that the names traditional health practitioner, traditional healer, traditional health doctor, medicine-man or doctor is also misleading. These are quasi-names that activists, propagandists, researchers, the government and the public are commonly used; clearly without understanding the real meaning of it. This encircling quasi-descriptive names make it possible for many people (possibly even more than the 200,000 alleged) to call and pride themselves traditional healers, as various researchers already had demonstrated.2,1,7,18

The name traditional healer is clearly a non-specific encircling name for various non-medical workers in South Africa. It is a mixture of indigenous spiritual, cultural and social work-types, totally outside the definition of practice, training or domain of any of the registered health professions like nurses, dentists, medical doctors, etc. This differentiation, especially when compared with the modern medical doctors who researchers and the public try to compare and identify with the traditional healer. A comprehensive study of career-literature describes also the traditional healers by many names. To name some of these personas: diviners, herbalists, traditional birth attendants or midwives, traditional surgeons, medicine-men, bonesetters, sorcerers, spiritual healers, home caregivers, traditional advice counsellors, holistic healers, faith healers, traditional doctors, spiritual practitioners, priests, psyche healers, traditional health clerks, diagnosticians.2,6,14,17-22

These various classifications, naming and definitions make the grouping of persons working in the traditional healing as a single group, to can be counted under the descriptive name traditional healers, basically impossible.

Use of statistical formula to determine the numbers of South African traditional healers

A more statistical and descriptive approach is thus needed to get an idea of (a) who qualifies to be a traditional health practitioner, as the Traditional Health Practitioners Act No 22 (2007) tries to describes him/her as a professional entity and (b) the true number of the unregistered traditional healers practising in South Africa.

One way is to differentiate on the one side between (a) the quasi-healer without any type of school education and professional training and on the other side (b) the group who obtained a school-leaving certificate and/or attend tertiary training. This differentiation is done on the principle that all the statutory recognized healthcare practitioners practising in South Africa must fulfil to minimum education and training to assure that they are able and skilled to deliver with safety healthcare services to the public.

To obtain insight in to the present-day status of the traditional healer’s school-leaving certificate and/or his attending tertiary training, various South African articles, books and other publication-matter were consulted with little success. A Lesotho-study by the ATPS17 could be identified to give a trustworthy guideline to compare the South African traditional healer’s scholastic/tertiary qualifications for instance with that of the western medical doctor. In this study17 a population of 91 traditional healers against 108 users (beneficiaries) of traditional medicines were researched.

Above data reflects that only 2.2 per cent of traditional healers have some form of tertiary education or attend in some way a post-grade-12 institution. This tentative tertiary certification makes the traditional healers comparable to the minimum school-leaving level of the registered or regulated healthcare professions, namely Grade 12. From this outcome, only 2.2 per cent of the alleged 200,000 traditional healers in South Africa are thus on a “comparable school leaving level” with the modern healthcare practitioners, especially the medical doctor, with who they are competing in the healthcare market and for a healthcare positioning. This means in terms of the classification of the ATPS17 (read together with the Pretorius-criteria11) at most 4,400 (2.2 per cent of the alleged 200,000 traditional healers) really qualify to be classified as traditional healers in South Africa, although still with certain limitations in terms of final school-leaving certification. This group still mostly lacks the post-grade-12 three to eight years of tertiary training of the healthcare practitioner.17

If a stricter “tertiary education” classification, stretching over five to six years after grade 12, similar to the M.Tech (Homeopathy) or the MB.ChB (Medicine), is brought into account, the chance is good that the estimated 2.2 per cent of the ATPS17 can be halved further to an 1 per cent of bona fide healers or 2,200 in number with an assumed tertiary training of three and more years against the alleged 200,000 traditional healers.

Above findings are in line with the present total registration membership of more or less 4,000 registrations that the allied professions in South Africa had reached only after nearly 40 years of regulation (against the 4,400 to be
“real” traditional healers) as calculated above. If only the present number of registered homeopaths, naturopaths and phytotherapists are taken into account after nearly 40 years of regulation, namely more or less 1,300 (against the 2,200 estimated bona fide traditional healers with some form of tertiary education), the outcome is still balancing.13,19,23

Above gives a good indication of the low number of registrations of bona fide traditional healers that can be expected in terms of the Traditional Health Practitioners Act No 22 (2007) if strict registration rules are followed. The “real” or bona fide traditional healers in South Africa can further be calculated by a combination of the research of Pretorius11 and the manifestos of various traditional healers organizations.12,24-26

Pretorius11 also doubts the trustworthiness of the alleged 200,000 traditional healers as quoted by researchers in South Africa, and, as the ATPS17 did, also the correctness of enrolled members as offered by the traditional healer organizations. Pretorius11 calculation is that only 10 per cent of all the so-called traditional healers are bona fide healers.

With reference to the membership numbers, as stated by various traditional healer organizations, it seems only to be the Traditional Healers Organization (THO) of all the healer organizations which openly declared that they have only 29,000 members. They also give a clear reason why this number is 29,000 and not the massive numbers of the other organizations: namely, because they use some kind of selection criteria for registration. As such, the leaders of the THO12,24-26 also allege they have sorted out to some extent the massive group of bogus healers by the following training and registration requirements: (a) own training of two years and mentorship as well as a further three years of part-time guidance and support; (b) to become a member of the THO already practicing traditional healers have to attend a oneday workshop to be introduced to the THO activities and a five-day workshop on traditional primary healthcare; (c) Persons who want to join the THO as healers must also produce a reference of good character.11,12,14,24-28

If the criteria of “three years or more tertiary training” is made applicable on the 29,000 THO-members by using the 10 per cent calculation of Pretorius,11 only 2,900 “real” or bona fide healers are reflected. This outcome is in line with the estimated 2,200 of this study, based on the 1 per cent criteria in terms of the ATPS17. The 2,900 seems even to correlate to a certain extent with the 2.2 per cent of the ATPS17 guideline that reflects 4,400 healers.

The 7:1 ratio-misled of traditional healers versus healthcare practitioners

A serious and misleading deception that spread direct out of the alleged 200,000 traditional healers assumption, is the habit to compare these untested number of an alleged 200,000 traditional healers specific with the total number of registered modern healthcare practitioners, especially medical doctors, in South Africa to support the allegation of 200,000 traditional healers in practice as true, as well as to support the assumption that there is an enormous need for their services. Some researchers indeed had referred in the past to this anomaly and contradiction in research- references and ask for cautiousness in interpretations. It seems as if this warning was clearly ignored by the most of researchers in their promotion of the traditional healers after 1994 in New South Africa. The end is a research- falsification, used exclusively to strengthen the believe of the alleged number of 200,000 traditional healers as true, as well to portray them in terms of these alleged numbers as prime role-players in the South African healthcare sector.6,11,17,18,22

Earlier as well as present-day presentations on the healthcare statistics of South Africa reflect the alleged 200,000 traditional healers versus 30,000 medical practitioners, projecting a ratio of 7:1 in favour of the traditional healers. [More recent statistics on Africa as a whole reflects even a ratio of so high as 80:1 between the numbers of traditional healers when compared with modern medical practitioners].5,6,19,28-34

Above outcomes support the view of a great demand for traditional healers, together with the existence of an alleged number of 200,000 and more traditional healers practicing in South Africa as a fact.

Hereto shows research that above comparisons and conclusions seem to be again manipulated, ignoring that there are in real live an enormous group of registered healthcare professions practicing and offering the same and better health services to the public as the alleged 200,000 traditional healers. It must further be emphasised that very few of the alleged group of 200,000 traditional healers are fulfilling the status-requirements of bona fide healers. These alleged 200,000 traditional healers must thus be compared with the total numbers of registered healthcare professions (like psychologists, pharmacists, doctors, allied professionals, dentists, nurses, welfare-practitioners,
etc.) in South Africa. These practitioners have statutory recognition and advanced scientific and practice training in healthcare that are overall of a much higher standard than that of the traditional healers. The total number of registered healthcare professionals reflected for 2013-2014 was 259,025. The number of medical doctors were 38,236, dentists 5,560, qualified nurses/midwives 124,045, allied auxiliary practitioners 43,584, practicing pharmacists 4,562, psychologists 6,019, social welfare practitioners 8,078 and non-practicing health practitioners 28,941.29,31

The above ratio-outcome of 7:1 for South Africa are clearly wrong and changes dramatically when the total number [all types registered with the Health Professions Council (HPCSA) and other Health Councils] of registered health professionals is taken into account, namely an alleged 200,000 traditional healers (all types seeing, that the term traditional healer can encircles also more than 20 kinds of traditional healers although Act No 22 only defined four) against 259,025 registered healthcare professionals (all types). The ratio dramatically changes to 1:1 (259,025: 200,000), with even a small favouring of the registered or regulated healthcare professionals.2,11,21,34-38

This outcome contradicts the strong demand of traditional healers as measured in terms of proportional numbers when comparing with all the registered healthcare practitioners.

When the groups are compared in terms of the total grouping of 259,025 qualified health professionals with the more trustworthy number of 4,400 selective “real” or bona fide traditional health practitioners (representing those 2.2 per cent with some tertiary training in terms of the APS17 guideline), the ratio is totally in favour of the already registered or regulated healthcare professions, namely a ratio of 59:1. When the 2,200 bona fide traditional healers (as calculated with the ATPS17-Pretorius15- criteria), who are assumed to have more than three years of tertiary training, are compared alone with the number of registered medical practitioners of more or less 38,000, the ratio is 17:1 in favour of the medical practitioners.

Above finding basically nullifies the alleged need of traditional healers, as previously reflected by the ratio of 7:1 in favour of the traditional healers. Indirect it also challenge the allegation of the presence of 200 000 traditional healers in practice in South Africa. It seems that it support the viewpoint and opinion of this research that the bona fide traditional healers of South Africa is insignificant.

**General South African Household Surveys: 2003–2013**

The General Household surveys, especially because it represent the clients’ views and opinions, show a far lower presence of traditional healers active inside the South Africa healthcare sector.39 It also reflects a constant decline in the usage of the traditional healer since 1990.39

For the period 2008 and 2011 the average usages were respectively 1.2 per cent and 1.4 per cent of the traditional healer as reported by specific Black South Africans.7,39

The national statistics of the General Household Survey of 2013 offer also very good insight into the possible number of bona fide traditional healers in South Africa. This survey’s statistics reflect for the period 2004 to 2013 (10 years) the preferred healthcare professionals that the public first contact in times of medical urgency: For the 10 years, the preference of the traditional healer was only an average of 0.2 per cent against the medical doctor’s average of 22.0 per cent.40 This reflect a ratio of 1:110 or a percentage comparison of only one traditional healer for every 100 doctors available in terms of the 2004 to 2013 statistics.40

When this 2004–2013 statistics are transferred to the usage, availability and presence in the community of healthcare providers, it means that for the 39,000 medical doctors registered in 2013, there were only 390 traditional healers in practice.7,30,39 This is in line with the 1.4 per cent average usage for 2011 which reflects only 546 traditional healers in practice against 39,000 medical doctors in terms of the percentage comparison.7,30,39

It is clear that in terms of above transformed-statistics that the South African traditional healers with a bona fide status – representing more trustworthy the true number of traditional healers of South Africa – are in terms of a strict selection criteria not more than 4,400. This number is a fraction of the untested, alleged 200,000 and more traditional healers reflected in the general literature on the South African traditional healing.
Discussion

It seems that the alleged number of 200,000 traditional healers practicing in South Africa is based on a WHO estimation of the 1960s. This untested figure became incorporated as true in research data and mind-set of researchers, activists and propagandists on South African traditional healing. These mal-thinking was supported and strengthened by various traditional healers, organisations with their inflated and doubtful numbers of members. Present-day findings opposed it strongly. It indicates the number of the South African traditional healers with true bona fide status not to be more than 4,400.

The traditional ratio of 7:1 reflected in general literature on the South African traditional healing, favouring traditional healers above medical doctors, is also contradicted by various new research-outcomes, making the need for the traditional healers in the South Africa society less prominent. It also dislodges the established belief of the presence of 200,000 traditional healers in practice in South Africa.

It is further clear that the definition traditional health practitioner, as inscribed in the Traditional Health Practitioners Act No 22 (2007), is undefined and insufficiently formulated. The present definition includes all kinds of non-formal practitioners, like caregivers, faith healers, priests, psyche-healers, etc. inflating the number of traditional healers in South Africa to be the alleged 200,000 and more.

Strength and limitations

Notwithstanding a lack of official South African documentation on traditional healing, the evidence obtained from contemporary and primary resources offered the opportunity to form objective viewpoints on the matter and to profile more clearly the traditional healer’s position in terms of numbers and need by the public.

Although this study includes cross-sections of the population using traditional healers, it would benefits if it also includes people who are not sick, who are not visiting a specific hospital, clinic or who have not already visited a modern-day health practitioner or a traditional healer, to obtain further detail information on matters like the usage, numbers and popularity of traditional healers. This research could not fully fulfill to this requirement as a result of costs and manpower.

Conclusion

The present existence of an alleged 200,000 and more traditional healers practicing in South Africa could not be confirmed. The same lack of a present confirmation about the alleged 7:1 ratio in favour of the traditional healers against the medical doctor was also reflected.

The present profile of South African traditional healers as an uniform group of healthcare professionals lacks; even the Traditional Health Practitioners Act No 22(2007) fails to define precise the present professional status and position of traditional healers in the South African healthcare sector.

The authors believe that the existence of an alleged 200,000 traditional healers in present day South Africa are totally over-estimated and misrepresented in numbers in research and in public talk. We believe that the bona fide traditional healers are a small, insignificant group.

We believe also that it is of utmost importance that the registration of the traditional health practitioners in terms of the Traditional Health Practitioners Act No 22 (2007) is been activated as soon as possible and that the registration-process is fully completed in 2017. Only with precise and descriptive statistics can the true number of traditional healers be mapped, as well as the viability and sustainability of the South African traditional healing be determined and constructive planning on its future be considered.

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**CONFLICTS OF INTEREST**

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ADDENDUM B2:

PUBLISHED ARTICLE 7

(CHapter 2)

DO THE MAJORITY OF SOUTH AFRICANS REGULARLY CONSULT TRADITIONAL HEALERS?

Do the majority of South Africans regularly consult traditional healers?

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ABSTRACT

Background
The statutory recognition of traditional healers as healthcare practitioners in South Africa in terms of the Traditional Health Practitioners Act 22 of 2007 is based on various assumptions, opinions and generalizations. One of the prominent views is that the majority of South Africans regularly consult traditional healers. It even has been alleged that this number can be as high as 80 per cent of the South African population. For medical doctors and other health practitioners registered with the Health Professions Council of South Africa (HPCSA), this new statutory status of traditional health practitioners, means the required presence of not only a healthcare competitor that can overstock the healthcare market with service lending, medical claims and healthcare costs, but also a competitor prone to malpractice.

Aims
The study aimed to determine if the majority of South Africans regularly consult traditional healers.

Methods
This is an exploratory and descriptive study following the modern historical approach of investigation and literature review. The emphasis is on using current documentation like articles, books and newspapers, as primary sources to determine if the majority of South Africans regularly consult traditional healers. The findings are offered in narrative form.
Results

It is clear that there is no trustworthy statistics on the percentages of South Africans using traditional healers. A scientific survey is needed to determine the extent to which traditional healers are consulted. This will only be possible after the Traditional Health Practitioners Act No 22 has been fully enacted and traditional health practitioners have become fully active in the healthcare sector.

Conclusion

In poorer, rural areas no more than 11.2 per cent of the South African population regularly consult traditional healers, while the figure for the total population seems to be no more than 1.4 per cent. The argument that the majority of South Africans regularly consult traditional healers is unsubstantiated.

Key Words

Malpractice, primary healthcare, statutory recognition, traditional healer, traditional health practitioner

What this study adds:

1. What is known about this subject?

In-depth research to support traditional healing in South Africa is scant and where existent, very superficial.

2. What new information is offered in this study?

Research data shows that the extent to which the public utilizes the service of traditional healers is insignificant.

3. What are the implications for research, policy, or practice?

The motives of the activists and politicians who promote Act No 22 (2007) are suspicious. Moreover, the viability and sustainability of traditional healing as a profession in the South African healthcare system is doubtful.

Background

In 2007 the Traditional Health Practitioners Act No 22 was promulgated in South Africa. The goal with this Act is to regulate traditional healers in South Africa as a specific group of healthcare practitioners. The Act offers traditional healers full professional status as healthcare professionals. In an effort to motivate the healthcare authorities of South Africa to regulate traditional healers, lobbyists offered various assumptions, arguments, opinions and statements as to why it is necessary to regulate traditional healers as a healthcare group. One of the many claims put forward by the activists and politicians in the promulgation application was that traditional healers play a valuable role in healthcare and that the majority of South Africans consult traditional healers regularly. The allegation was that as many as 80 per cent of the total South African population regularly make use of this service.¹⁻⁹

Current literature still reflects this view that the majority of South Africans regularly consult traditional healers, especially the view that the figure can be as high as 80 per cent of the population. An overview of the literature that makes reference to the 80 per cent consultation rate in South Africa uncovered more than 50 authors who use this statistic. This percentage was already old news in the 1980s in South Africa.¹⁻¹⁹

The various arguments, motivations and views on frequent usage of traditional healers in the application in 2007 to promulgate the Traditional Health Practitioners Act No 22 (2007) are supported by information collected by an internal committee on traditional healing in 1992, a national steering committee in 1993, a provincial standing committee on health in 1997 and a national council of provinces committee in 1998.²⁰⁻²⁶

The Department of Health (DoH) also held a series of road shows during 2001 to 2002 to gather information on the need for traditional healers in the future healthcare of South Africa. Political and cultural agents and drivers, focussing exclusively on traditional healers as a Black tradition and custom, and not so much as a needed and prominent healthcare practitioner, seem to be strong role players in the early hearings to regulate traditional healers.²⁰⁻²⁶

Is the assumption that the majority of South Africans regularly consult traditional healers true or false? Also, is the view that 80 per cent South Africans regularly consult traditional healers, true or false?
The aim of this study is to determine if the majority of South Africans regularly consult traditional healers. This is crucial in light of the pending full enactment of the Traditional Health Practitioners Act No 22 (2007) with its penetration of all facets of the formal healthcare sector and the seemingly massive 80 per cent intake of patients by traditional healing in the future.

Method

The research was done by means of a literature review. This method has the aim of formulating a view based on the available research evidence. This approach is used in modern historical research where there is a lack of information on a topic. The databases used were EBSCOHost, Sabin online and various contemporary sources like newspapers for the period 1988 to 1989, articles from 1988 to 2016, books for the period 1990 to 2013 and governmental documents covering the period 1995 to 2016. These sources were probed to find out if the majority of South Africans regularly consult traditional healers. The findings are offered in narrative form.

Results

The fact that the Traditional Health Practitioners Act No 22 has not been fully enacted and that there are no statistics on consultation and practice rates from registered traditional health practitioners for analysis, nor any data collected by the Traditional Health Practitioners Council (THPC) or by medical funds and schemes, means that a statistical conclusion requires another approach.

Given this statistical shortcoming, a literature review seems the most appropriate approach to analyse the claim of some researchers that the majority South Africans regularly consult traditional healers. The same approach can be followed to determine if 80 per cent of South Africans regularly consult traditional healers.

The discussion analyses and evaluates the findings, conclusions, opinions and views of different researchers on the need for the usage rates and the popularity of traditional healers in South Africa.

Discussion

South African reports on the use of traditional healers

Contemporary data on the use and popularity of traditional healers in South Africa reflect a different picture than the arguments, statements and views offered in the 1990s to motivate regulation through the Traditional Health Practitioners Act No 22 (2007).

First, statistics on South African traditional healers show that the visits to traditional healers are mostly “culturally” driven instead of medically needed as lobbyists tried to claim in their projection of traditional healers as a kind of medical doctor. The findings of a South African household study shows that of the 19 most popular “medical preparations” used by traditional healers, as many as 17 (89.4 per cent) are used exclusively for shamanism (like enhancing luck in love and careers, appeasing ancestors and avoiding disastrous situations).

Scholars are furthermore of the opinion that if South African Household Surveys were more specific in questioning and use a question that asks about ancestor worship or even about issues of a more psychological nature, it would long since have revealed that traditional healers are not as often consulted for physical conditions. This would be a truer reflection of role of such practitioners. They are in fact spiritual healers. This type of consultation is more appropriately one of divining (spiritual and psychological), rather than herbal (traditional medical).

Second, various other South African household studies in the period 2003 to 2013 reflect an insignificant role for traditional healers, not only in the healthcare sector specifically, but also in community life. It is reported that since 1990 there has been a constant decline in traditional consultations in South Africa.

One of these South African studies showed in 2003 that the monthly consultation rate of traditional healers was 5.2 per cent. A further consultation rate of 6.0 per cent was reported for faith healers. This means that 11.2 per cent of the public made use of the traditional healer in 2003 in some way in South Africa. What is clear is that in 2003, 88.8 per cent of the population did not make use of the traditional healer at any way.

For the period 2008 to 2011, the use of traditional healers by Black South Africans decreased dramatically to only 1.2 per cent in 2008 and 1.4 per cent in 2011 measured as consultations per month. In terms of monthly visits, visits to traditional healers are rare (0.02 visits), especially compared to the utilization rates of public sector clinics (0.18 visits) and hospitals (0.09 visits). When comparing traditional healers’ popularity and use with that of medical doctors, the ratio for traditional healers was very low (1:110). It seems that Black households prefer the use of
public health facilities that offer a variety of regulated healthcare practitioners (mostly medical doctors and nurses). For this period, public non-use of traditional healers was 81.3 per cent, nearly the same as the 2003 finding of 88.8 per cent.\(^3\)\(^{33}\)

The 2013 South African Survey\(^{27}\) reflects a consultation rate of only 0.1 per cent of traditional healers as the first choice healthcare practitioners in the consultation line. The 2013 consultation rate for medical practitioners is 21 per cent. This reflects again a low ratio for traditional healers against medical practitioners (1:220). For the period 2004 to 2013, the average consultation rate for traditional healers was only 0.2 per cent, compared with an average rate of medical doctors of 22 per cent (ratio 1:110). When the percentages of consultation of traditional healers and medical doctors are compared, the use of traditional healers is less than 1.0 per cent, reflecting an insignificant presence in the general South African healthcare setup.\(^{34}\)

This 1.0 per cent average for 2004 to 2013 contradicts the 5.2 per cent of the 2003 Survey\(^{25}\) but confirms the 2008 and 2011 Surveys that showed only between 1.2 per cent and 1.4 per cent use of traditional healers in South Africa.\(^{33}\)

Medical schemes expenditure on health practitioners for 2005

Another way to calculate the percentage input of traditional healers in the present South African healthcare system is to compare them with allied professions in terms of practice income and the sales of products. Both traditional healers and allied professions practise mostly outside formal healthcare, with overlapping interests in a dual healthcare system. Allied professions have been officially regulated for more than 30 years. Positive numbers for this sector would surely predict positive outcomes (but possibly an over-estimation) for traditional healers.

The total income generated in 2005 in South Africa by allied professions was R97 033 651, while that of medical doctors was R4 402 206 860. This represents an income of only 2.2 per cent for allied professions compared with the income of medical doctors. When only the consultation income between the two groups is calculated for 2005 (allied professions R62 073 868; medical doctors R3 633 078 604), the ratio is less than 1 per cent. In terms of dispensing income (allied professions R34 959 868; medical doctors R769 128 256) the ratio is less than 5 per cent. These outcomes indeed reflected that allied healthcare practitioners have a very limited role in South African healthcare.\(^4\)

Given the results for the allied professions, traditional healers will most probably be limited to an insignificant role in formal healthcare in terms of income analysis. This outcome seems to be in line with the findings of the South African Household Surveys of 2008 to 2013 on traditional healers that found a very low level use, varying between 1.0 per cent and 1.4 per cent.\(^4\)\(^{34}\)

Poor areas and its use of traditional healers

Researchers claim that in certain areas in South Africa (that they described as the so-called poorest areas), a larger number of the population use traditional healers. In practice, it seems that this data only apply to small segments in the rural areas of South Africa. These areas are isolated and there is an absence of proper medical facilities and staff.\(^{30,31}\)

Of the so-called 80 per cent of poor people in the formal sector of South Africa, at most 11.2 per cent used traditional healers in 2003. In reality, only 5.2 per cent of the public really contact traditional healers for medical preparations and medical treatments. This means that as much as 88.8 per cent of the total poor population of South Africa do not use traditional healers. These “poor” users had declined dramatically since 2003 to 1.4 per cent in 2011.\(^{30,31,33}\)

To argue that 80 per cent of the total South African population is reliant on traditional healers, is deceptive.\(^{30,31}\)

The World Health Organization (WHO) and the alleged 80 per cent South African consultation rate

Gumede\(^3\) wrote in 1990: “A point well made, but 80 per cent of patients in this region (with a plus minus 40 per cent urbanization) visit the traditional healer before they see the modern practitioner – a clear vote of more confidence in the traditional healer” (p. 208). This argument was used by activists, politicians and traditional healers to have traditional healers regulated in 2007 by the Traditional Health Practitioners Act No 22. It is frequently used to argue that South African patients have more confidence in traditional healers than modern medical doctors. However, proponents do not offer any statistics to confirm it.
Gumede, an eminent expert on South African traditional healers and himself a registered and practicing medical doctor, had confidence in 1990 in the truth of this claim that 80 per cent of the South African public use traditional healers. Where did he obtain this information for his research and to support his opinion?

Gumede’s view seems to be based on a 30-year-old statement that 80 per cent of the world population makes use of traditional healers, used originally in a book *Traditional Medicine and Health Care Coverage* that was published in 1983 by the World Health Organization (WHO). Robert Bannerman, a WHO regional advisor and manager of the traditional medicine programme of the WHO at that time, wrote in this publication:19, In many of these developing countries primary healthcare devolves on the healer, herbalist, traditional midwife, and other traditional practitioners. These are the health workers that offer services to the disadvantaged groups that total about 80 per cent of the world’s population and have no easy access to any permanent form of healthcare” (p. 320).

Notwithstanding the fact that Bannerman failed to offer any evidence, reference or other data to support his statement, it became, as with many other statements and claims on traditional healthcare, distorted with time and a driving force of its own, including in South Africa. He surely did not intend the statement as such at that time. He was focussing on access to healthcare. The fact that WHO reports re-use information without retesting one report before use in another has become the main driver for this issue. Bannerman’s non-specific remark about healers, herbalists, traditional midwives and other traditional practitioners that can offer services to the disadvantaged groups, which total about 80 per cent of world’s population, has changed meaning in later publications. Finally, it resulted in the claim that 80 per cent of the population depends on traditional medicine or that 80 per cent of the African population uses traditional medicine to help meet their healthcare needs and that traditional medicine is the first source of healthcare for about 80 per cent of the population in developing countries20 (par. 2).

Other WHO publications (like *Promoting the Role of Traditional Medicine in Health Systems: A Strategy for the African Region 2001-2010 and Traditional Medicine Strategy 2002-2005*), also adopted this distorted reading of the original version by Bannerman. This claim has remained the primary source for researchers due to the credibility of the WHO, without anyone asking about the trustworthiness of research facts or data. This circulated out also to other important opinion makers, such as BBC News, which carried an article in 2013 about traditional healers in South Africa, claiming that these healers remain the first point of contact for physical and psychological ailments for about 80 per cent of the Black South Africans. The same can be said for the South African Medical Journal (SAMJ) in 2012 when it suggest that in some cases 80 per cent of South Africans use traditional medicine to meet their primary healthcare needs. Multiple researchers have quoted this percentage in their articles, presentations and books22 (par. 3–40).

This claim of an 80 per cent utilization rate has been made applicable to the populations of Southern Africa. It became a convincing argument in favour of regulating traditional healers in terms of the Traditional Health Practitioners Act No 22 as valuable and sustainable healthcare practice for South Africa.5,13,29,33,35,36

**Strength and limitations**

This study contradicts the argument that the majority of South Africans or as much as 80 per cent of the population regularly consult traditional healers.

South African healthcare authorities have neglected to do an in-depth and objective study on South African traditional healers to profile the activities of traditional healers with sound information. This oversight makes this study a limited country-wide statistical conclusion.

**Conclusion**

The argument that the majority of South Africans regularly consult traditional healers is unsubstantiated. The commonly quoted South African consultation rate of 80 per cent is also unsubstantiated. This 80 per cent is an outdated 30-year-old statement that is irrelevant in terms of the utilization of South African traditional healers.33,34

The arguments, opinions and evidence offered in 2007 to support the regulation of traditional healers and the promulgation of the Traditional Health Practitioners Act No 22, were therefore flawed and distorted.
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ARE THE FEES THAT THE TRADITIONAL HEALTH PRACTITIONER CHARGES GENERALLY LOWER THAN THAT OF THE MEDICAL PRACTITIONER?


[Archives Australasian Medical Journal; Vol. 10 (2017), No. 1: Are the fees that the traditional health practitioner charges generally lower than that of the medical practitioner?]
Are the fees that the traditional health practitioner charges generally lower than that of the medical practitioner?

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ABSTRACT

Background
The cost of healthcare is a matter of concern for the public and the authorities. When a new healthcare provider enters the healthcare market, specifically the private sector, it is crucial to know if the fees will be affordable, especially when that service provider claims to be able to offer a far less expensive service than his competitors. The newcomer, the traditional health practitioner, was awarded statutory status in South Africa in terms of the Traditional Health Practitioners Act No 22 (2007). Although the training and skills of the various types of health practitioners are central to their ability to deliver an effective health service and influence the specific fee that the practitioner will charge, the focus of this research is only the financial aspect. Factors such as the nature, complexity, risk and difficulty level of procedures influence fees. The question here is whether the traditional health practitioner’s fees are in general lower in comparison with that of the medical practitioner.

Aims
The study aimed to determine if the fees of the traditional health practitioner are in general lower in comparison with that of the medical practitioner.
Methods

This is an exploratory and descriptive study that makes use of a historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on whether the fees of the traditional health practitioner are generally lower than that of the medical practitioner. The findings are offered in narrative form.

Results

The research could not uncover any evidence to support the claim that the fees of the traditional health practitioner are lower in comparison with that of the medical practitioner.

Conclusion

This research could not confirm that the fees of the traditional health practitioner are in general lower when compared with that of the medical practitioner.

Key Words

Healthcare, medical practitioner, modern medicine, service costs, statutory status, traditional health practitioner

What this study adds:

1. What is known about this subject?

Literature offers limited information on this topic.

2. What new information is offered in this study?

The study found that the argument that the fees of the traditional health practitioner are in general lower than that of the medical practitioner is not supported. It can therefore not be offered as a reason to promote traditional healing.

3. What are the implications for research, policy, or practice?

The view of the traditional health practitioner as an inexpensive healthcare provider is inaccurate.

Background

The cost of healthcare is of great importance in South Africa, especially for the poor sector of the country. The post-1994 government has exerted itself to offer an inexpensive healthcare service to the poor. Various initiatives are prominent, including both public and private delivery of healthcare. Central to healthcare delivery are the various practitioners, like nurses, dentists, medical practitioners and others. Many of these practitioners work in the public sector, but the majority in the private sector, either as employees or self-employed.

The regulation of specific groups of health practitioners in South Africa is not a new phenomenon. In the 1970s, government introduced the regulation of psychologists and later in the 1980s the allied health practitioners followed. The public demand for a specific health practitioner lies at the basis of regulation. In the case of the traditional health practitioner, the authorities and the traditional health practitioners offered certain reasons why it is of utmost importance to include this fraternity as healthcare practitioners in the private sector of the South African healthcare establishment.\(^1\)\(^-\)\(^7\)

One of the main pleas to regulate the traditional health practitioners claimed that these healers offer an affordable health service to the poor, especially in isolated rural areas, because the fees and costs of practice are generally less expensive than that of the medical practitioner. This plea was strengthened by the argument that there is a shortage of public and private health practitioners who work in these areas and that public services like clinics and hospitals fail to offer much needed healthcare.\(^8\)\(^-\)\(^10\) The aim of this study is to determine if the traditional health practitioner’s fees are in fact lower in comparison with that of the medical practitioner.

Method

The research was done by means of a literature review. This method entails formulating a view based on the evidence presented in the literature. This approach is used in modern historical research centering on topics about which there is little information. The databases used were EBSCOHost, Sabinet online and various contemporary
sources like newspapers and reports for the period 2003 to 2013, articles from 1992 to 2014 and books for the period 1990 to 2014. These sources were consulted in an effort to reflect on the fees and costs of traditional health practitioners and medical practitioners.11,12 The findings are offered in narrative form.

Results

The available literature reveals that the implementation of the Traditional Health Practitioners Act No 22 of 2007 has been limited despite the fact that it was promulgated nine years ago. No fee structures are described in the Act and even the registration of traditional health practitioners has not progressed. Traditional health practitioner organizations also lack the internal structures and leverage to prescribe fees and to enforce pricing for diagnosis, treatment procedures and self-made medicines. Pricing is decided individually by each traditional health practitioner.

The fact that the Traditional Health Practitioners Council (THPC) has failed to open a register and had not registered traditional health practitioners formally, makes it very difficult to distinguish between competent and incompetent healers. The information provided by these unregistered healers can be misleading.

The fees that medical practitioners may charge for diagnosis and treatment procedures are not statutorily fixed. They are free to decide on their own fees. The only price-fixing with regard to their diagnoses, treatment procedures and services is that of the medical funds and schemes that declare a maximum price-listing for each service. In many cases, the fees asked by medical practitioners, especially medical specialists are up to three times that of the maximum prices paid out by the medical funds and schemes.

It is impossible to directly compare the fees of traditional health practitioners and medical practitioners in terms of money value based on a statistical analysis.

A statistical analysis based on the presumed low fees and cost structure of the traditional health practitioner compared with the alleged high fees and costs of the medical practitioner is also unrealistic. They are two very different groups from different time frames and development levels. On the one hand one has the medical practitioner, a very modern, skilled professional with scientific training, know-how and professional ethics, backed up by a sophisticated medical and scientific technology industry and healthcare establishment. On the other hand there is the traditional health practitioner, a pre-modern healer without any proven training or medical knowledge and with no formal professional ethics and sound formal practice control.

For a lack of statistical information, this study embarks on a literature review of publications that describe the cost of services. The findings from literature are presented in the discussion.

Discussion

One of the arguments in favour of regulating the traditional health practitioner was that modern medical practitioners charge high fees and involves cost, over against the low fees and costs of the traditional health practitioner. The fact that these arguments are prominently and constantly reflected in literature and presented to the public as true, together with the argument that there are 200,000 traditional health practitioners in South Africa and that 80 per cent of the South African public regularly consult the traditional health practitioner, justify this research.13-21

Fees and costs system of the traditional health practitioner There is in fact South African literature that thoroughly investigates the fee and cost structure of traditional health practitioners versus medical practitioners.

This literature shows that the fees and costs are almost the same for the two groups, notwithstanding the higher training of the medical practitioner versus the lack of formal medical training of the traditional health practitioner.8–10,22

The only clear difference between the two kinds of healers is the patient-friendly payment system of the traditional health practitioner. This group follows a far more flexible approach regarding payment than the medical practitioner in his practice. It is not necessarily always more affordable, but it does in general accommodate the personal financial needs of the clients. To make payment easy, especially in the rural areas, the traditional health practitioners accept payments in cash and in livestock. In addition, some of the traditional health practitioners also follow a policy of “no payment for none cure”. Undoubtedly, this guaranteed outcome offered by the traditional health practitioner holds financial benefits for his clients and lowers the end costs.8–10,22
Some traditional health practitioners also follow a policy of one-off payments for multiple services over a period of time. This minimizes the stress on the poor client’s cash outlay every time he visits the traditional health practitioner, either for a specific ailment or for various ailments treated over an extended period. Undoubtedly, such a comprehensive service where the healer down-prices his final charge, benefits the clients. These practices can contribute to the perception of low costs.8-10,22

Conversely, researchers also show that the traditional health practitioner’s fees and costs can directly contribute to the higher living costs of poor households. This may be a reason why the use of traditional health practitioners is declining when free, effective government health services and qualified healthcare practitioners are available. Researchers point out that visits to a traditional health practitioner can cost up to 10 per cent of the household expenditure per annum. In this context, a cost of 5 per cent is already a heavy burden on a poor family’s budget, while a cost of 10 per cent and above can be catastrophic and can with the argument that there are 200,000 traditional health practitioners in South Africa and that 80 per cent of the South African public regularly consult the traditional health practitioner, justify this research.13-21

The simultaneous use of the traditional health practitioner and the medical practitioner can double the medical expenditure of poor households. This double use can wrongfully lead to a perception that the medical practitioner’s healthcare service is expensive, while the costs of the traditional health practitioner is not at all brought into consideration as a contribution to the problem. One has to further take into account that the traditional health practitioner’s treatment does not always bring healing and that the patient may in the end be forced to incur extra costs for modern healthcare treatment from the medical practitioner. Not only does this negative outcome render the service of the traditional health practitioner less inexpensive, but the extra costs and emergency services rendered by the medical practitioner to rectify the traditional health practitioner’s mistakes, erroneously reflect on the medical practitioner’s income system as normal services rendered, heightening his fees and costs profile.8,9,10,22

Gumede8 provides a different perspective on the traditional health practitioner’s “no payment for no cure” and “once-off payment” practice as described by researchers. He mentions that there is a “small retaining fee”, a so-called “doctor’s fee for opening his doctor’s bag” for the first consultation by the traditional health practitioner (p. 90). Regarding the amount to pay for treatment at the end, Gumede says that “the fee was well known to all and sundry; it was a beast - an ox or a cow”. This means that the once-off payment for traditional health practitioners can be up to R5,000 and more. This amount is surely not a low fee or an inexpensive cost to the patient. In this instance, it must be noted that this was the fee for 1990, excluding inflation of a 26 years period.8

This expensive fee structure of the traditional health practitioner is also confirmed by the study of Flint and Payne23 in the Eastern Cape. They investigated traditional health practitioners’ treatment of HIV/AIDS with uBejane (a rhino muti cure). In 2006, this cost R300 per visit, with rates as high as R2,000 if animal sacrifices are included.

The negative impact of the failed official healthcare system

Modern hospitals and medical facilities situated in urban areas are sometimes difficult to reach for many poor people, especially in deep rural areas. Journeys involve long distances, poor public transport facilities and expensive taxis. With vast areas of land and poor road and transportation systems, many people have to travel long distances on foot to reach medical help. Once they arrive, they are often required to wait in queues for hours as the shortage of clinics and resources cause overcrowding. Medicines are not always readily available at district clinics, even at hospitals. Patients are often not informed about the cause of their illness or given any information about it at all. This leads not only to personal and health insecurity, but to patients remaining uninformed about preventing or handling specific ailments. This situation creates hostility among poor patients and results in them staying away from public healthcare facilities. Alternative medical help and services, like that of the traditional health practitioner, becomes their only alternative.9,15

These situations promote the services of traditional health practitioners, not necessarily because they offer trustworthy and beneficial medical services, but purely because they are the only type of health service immediately and locally available. This government failure to offer an effective medical system in the rural areas has, especially in the past, created a false impression of the traditional health practitioner’s services being cheap and effective. The sub-standard health system of the government and the extra costs it brings for the poor when they have to use the traditional health practitioner as an alternative has nothing to do with the medical practitioner and his fee structure. This failed official healthcare system and incorrect reporting in research are an injustice
to the South African medical practitioner as a professional. The use of these one-sided perceptions of the medical practitioner’s fee structure in the literature is misleading.\textsuperscript{9,10,19,20,22,24–26}

The fact that the South African government fails to train enough medical practitioners also reflects badly on the medical practitioner’s fees and cost structure. This can relate to his salary in public service or the income generated from his private practice. The shortage in medical practitioners has led to increased demand for their services, which pushes up their income. This failure to train enough medical practitioners is illustrated by the fact that the eight local medical schools only deliver 1,200 medical practitioners annually compared to a much poorer and under-developed Cuba’s output of 50,000 medical practitioners per year. Medical training is therefore another government problem that is now incorrectly and unjustly transferred to the medical practitioner’s fees and costs.\textsuperscript{27–30}

It must, however, be acknowledged that the South African Government has done much since 1994 to bring free and inexpensive healthcare to the poor in rural areas. More than 1,600 clinics have been built or upgraded and staffed with qualified practitioners, while free healthcare is available for children under six and for pregnant and breast-feeding mothers. The pre-1994 healthcare system, in which hospitals were run on Apartheid principles to benefit Whites, was also successfully abolished, giving a much higher healthcare allocation to the poor. More than 260,000 healthcare professionals are now available to patients in some form. The district nurses furthermore play an important role in rural communities. These developments minimize the role of the traditional health practitioner and his services in rural healthcare. This lower demand for his services seems to force him to lower his fees to make a living.\textsuperscript{6,16,18,31}

**Insignificant role of the traditional health practitioner in the healthcare system**

Regarding the role and public use of the traditional health practitioner, it is important to note that a 2008 National Household Survey shows that the use of traditional health practitioners has declined in tandem with an increase in the wealth of patients. The poorest patient group had an average of 0.03 visits the previous month to the traditional health practitioner, while the wealthiest group had 0.002 visits to the traditional health practitioner.\textsuperscript{9}

As reflected above, the use of the traditional health practitioner is considerably lower than the use of public sector health services, which includes the medical practitioner working in the system (0.18 to 0.09 visits). Visits to public sector health services also declined with an increase in socio-economic status as wealthier patients make considerably more use of private health services. It seems that the older age groups (median age 35 years) make more use of traditional health practitioners than the younger and more modern groups (median age 23 years). It is clear that the new Black middle class (and upwards), who is surely in a better financial situation and are less traditional, is moving into the use of modern medicine, leaving the traditional health practitioner out in the cold.\textsuperscript{9}

In 2003, there was an 11.2 per cent use of the traditional health practitioner by limited segments of the population. Of this 11.2 per cent, less than 10 per cent had used the traditional health practitioner for ‘medical work’. In practice, only 1.2 per cent of the total population used the traditional health practitioner as a healthcare practitioner. Since 2008, various comprehensive National Surveys country-wide showed that the use of the traditional health practitioner, especially by Black South Africans, was never more than 1.4 per cent of the total population. Official research also reflects that since 1990 there has been a constant decline in the use of traditional health practitioners, basically because they are increasingly being replaced by better and cheaper public healthcare services and practitioners. This confirms that public use of the health services offered by the traditional health practitioner is insignificant and not always as inexpensive as claimed.\textsuperscript{8,9,15}

The arguments about the lower fees and costs of the traditional health practitioner, when compared with that of the medical practitioner, is not really accurate.\textsuperscript{9,16,21}

**Role of socio-political intentions**

There seems to be a hidden political agenda behind the rhetoric of the lower fees and costs of the traditional health practitioner compared with that of the medical practitioner. It is clear that the medical practitioner is not too expensive, below standard or provides inadequate health services. The perception of low fees and costs of the traditional health practitioner is kept alive with a political agenda to maintain the traditional health practitioner as a cultural and political institution.\textsuperscript{32–36}
The following remark confirms these hidden intentions:25 “Western medicine removes native Africans from the culture and tradition and forces them into a setting that they are not comfortable with, away from their family and traditions which are of utmost importance to them. They do not get the proper spiritual healing that their culture seeks and traditional ideology requires” (par. 1).

Strength and limitations
The study is a first to focus on dubious research that portrays the traditional health practitioner’s fees and costs as lower than that of the medical practitioner.

The study was limited by a lack of official information such as income statistics on the traditional health practitioner.

Conclusion
This study could not conclude that the fees and costs of the traditional health practitioner are lower than that of the medical practitioner.

The research rather shows that the fees and costs of the traditional health practitioner are not lower than that of the medical practitioner.

The arguments put forward in 2007 claiming that the traditional health practitioner’s fees and costs are lower than that of the medical practitioner is incorrect. The claim was put forward in an effort to advance the cause of regulating traditional healing as a health profession in South Africa.

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(CHAPTER 2)

TRUE OWNERSHIP OF TRADITIONAL MEDICINES IN SOUTH AFRICA


[Archives Australasian Medical Journal; Vol. 10 (2017), No. 4: True ownership of traditional medicines in South Africa]
True ownership of traditional medicines in South Africa

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ABSTRACT

Background

Literature postulates that traditional medicines form an important part of modern-day South African healthcare. The belief is that the traditional healer and traditional medicine is a close-knit unit, with the traditional healer as the true owner and manufacturer of traditional medicines. Various studies also postulate that the growth and development of South African traditional medicines are restricted by the pharmaceutical industries and other role players like the medical fraternity.

Aims

The present study aimed to determine who holds the true ownership of traditional medicines in South Africa.

Methods

This is an exploratory and descriptive study that makes use of an historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on the thinking and opinion on the true ownership of traditional medicines in South Africa. The findings are offered in narrative form.
Results
Many more role players are active in today’s traditional medicines manufacturing industry than merely the traditional healer and the traditional fraternity. The literature on traditional medicines fails to show the public the true meaning of traditional medicine in modern-day South Africa and to whom it really belongs. An in-depth analysis and understanding of the Regulations of the Traditional Health Practitioners Act (Act No 22, 2007), and of the definitions traditional philosophy and traditional medicines as reflected by the Act are totally missing from the literature. Such an investigation will aid in uncovering the true ownership of traditional medicines.

Conclusion
There is a clear differentiation between the dominant (real) traditional medicines and the inferior pre-modern traditional products of the traditional healer. The title deed or card and transport of traditional medicine are held by various public and private institutions and other entities, not exclusively by the traditional healer fraternity.

Key Words
Cartels, complementary, concoctions, indigenous, muti, pre- modern, supplementary

What this study adds:
1. What is known about this subject?
Most literature shows a misconception about what traditional medicines really are.

2. What new information is offered in this study?
The present study clearly delineates traditional medicines and traditional medical products (mixtures).

3, What are the implications for research, policy, or practice?
The traditional healer and his so-called medical products play an insignificant role in the traditional medicines industry and must be treated with utmost caution.

Background
South African literature on traditional healing offers opinions, statements and views on the excellence of traditional medicines and alleges that there is currently a dramatic evolution in traditional medicines here and world- wide. Sources also allude to the view that the South African traditional healer’s medicines and practices were blocked by White supremacy over many years. This has stunted its development and created the situation where it is ignored by the official healthcare sector and most of the public.\(^1\,^9\)

Regarding the assumed intellectual property rights over the so-called existing Traditional African Medicines (TAM), researchers argue that the power of the multinational pharmaceutical industry, together with cultural imperialism, had marginalized the industry. It is specifically alleged that the lobbying by pharmaceutical cartels after 1994, together with hostile attitudes of medical doctors and the medicine regulators, are destroying the South African traditional healer’s unique traditional medicines.\(^8\,\)\(^\,^13\)

Even the good names of official South African bodies are selectively misused to create and promote the impression that there is a so-called “South African traditional medicine culture”. Sources cite information collected worldwide that is clearly applicable solely to the supplementary/ complementary medicine (CAM) industries and not to South African traditional healing, as part and parcel of the so-called TAM of the traditional healing fraternity.\(^11\) The many opinions and views offered in the literature sketches a picture of the so-called excellence of the traditional healer’s medicines and of an excellent traditional health service offered by the traditional healer. It is furthermore alleged that traditional medicines and the traditional healer are all part of a unique, close-knit unity that is unbreakable and inseparable in the traditional healthcare fraternity, and as such that traditional medicines are the exclusive domain of the traditional healer. For the propagandists of traditional healing there seems to be no differentiation between the kinds of traditional medicines, as fields that are driven, executed and belong to different role players in the South African healthcare sector. The objections of the regulated allied health professions and the supplementary/complementary manufacturers that traditional medicines are their domain
and that there is a misconception in the minds of the traditional healing fraternity and their propagandists who reflect their traditional products as similar to (real) traditional medicines, are bluntly ignored.\textsuperscript{6,10-13}

Currently it seems that the true ownership of traditional medicines, with or without the prefix \textit{real}, is a point for debate, especially the conception that traditional medicines are the sole domain of traditional healing is controversial and has to be addressed.

The aim of this research is to determine the true ownership of traditional medicines in South Africa.

\textbf{Method}

The research was done by means of a literature review. This method entails formulating a view based on the available research evidence. This approach is used in modern historical research where there is a lack of information on a topic. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for the period 2014, articles from 1999 to 2016, books for the period 1992 to 2013 and governmental documents covering the period 2007. These sources were probed to find out if the traditional healers of South Africa are the true owners of traditional medicines.

The findings are offered in narrative form.

\textbf{Results}

\textbf{The history of South African traditional healers in perspective}

Indigenous traditional medicines were surely a strong competitor for European traditional medicines when last-mentioned made its appearance at the Cape of Good Hope in 1652. On the other hand, is it clear that it was due to the indigenous traditional healer’s own ignorance, his spiritual orientation and his lack of medical science that he never became a role player in mainstream health delivery, which erased his indigenous medicines from the South African scene? The Second World War gave further direction and added dimensions to South African scientific healthcare; a health complex to which indigenous traditional medicines did not belong for a long time. They were still stuck in the dimensions of the healthcare of the 1600s.\textsuperscript{6,16}

Since 1960s, it was specifically identified that traditional healing, the traditional healer and his traditional products moved to the foreground in South Africa, not because of an urgent need for them, but because they had become a political determinant and pivot to enforce certain streams of thought and practice. This South African movement gained momentum after the post-1994 political dispensation and had the support of not only the traditional healing fraternity and sympathy politicians, but also the activists and lobbyists of traditional healing. These groups offered various opinions and statements as true about the absolute needs and profits of the South African traditional healer’s (indigenous) traditional medical products to healthcare.\textsuperscript{1,6,16,17}

An in-depth investigation shows that most of these pieces of supporting evidence frequently mentioned in articles, books and other reporting were based on misleading “Bannermanistic” beliefs, statistics and superficial thinking, stretching over more than 30 years; presented over and over, whether artificial, trivial, true or false. A cleansing of these “Bannermanisms”, churning and falsities was undoubtedly needed in South Africa before the Traditional Health Practitioners Act No 22 (2007) could be promulgated as an Act.\textsuperscript{1,6,16,17}

The belief about the existence of the exclusive TAM of the traditional healer in South Africa is part of this “Bannermanism” and should be addressed as true or false. Specifically, the present ownership of traditional medicine in South Africa should be clarified.

\textbf{Act No 22’s descriptions and the lack of a South African traditional healer’s medicine culture}

In South Africa, \textit{traditional medicine} is a definition that is incorporated into the wide-ranging definition \textit{traditional philosophy} of Section 1 of the Traditional Health Practitioners Act No 22 of 2007. The Act’s functioning is driven by the definition of \textit{traditional philosophy} as “indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and the use of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation and whether supported by science or not, and which are generally used in traditional health practice”.\textsuperscript{18}

First, the description of traditional medicines in the Traditional Health Practitioners Act No 22 (2007) already reflects the ignorance of the traditional healing fraternity regarding an understanding of what traditional medicines
truly means and are in practice for them. Second, the definition itself is a public acknowledgement by the Traditional Health Practitioners Act No 22 (2007) that at present there is no indigenous traditional medicines culture unique to traditional healing in South Africa. This total absence of an existing indigenous traditional medicines culture and intellectual property rights are well reflected in the wording of “traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not”. This kind of phrasing as part of an Act’s definition is nothing else than dark Middle Age mythology writing and storytelling.

This official absence of an existing South African indigenous traditional medicine culture is further reflected by Section 1 of the Traditional Health Practitioners Act No 22’s superficial and insufficient description that traditional medicine is only “an object or substance used in traditional health practice”. This once more presents constructive evidence of the lack of an indigenous traditional medicines culture in South Africa, a further acknowledgement by the traditional fraternity of their failure to offer a unique traditional medicines culture. There is, in terms of the Traditional Health Practitioners Act No 22, of which the main intention is to regulate and to guard the interests of tradition healing, nothing concrete in evidence to lay claim on an established science of traditional medicines or to demonstrate through any written documentation of the fraternity’s intellectual and property rights on certain traditional medicines that are in use as scientific matter or profit, either by them or the established healthcare.18

This shortcoming in the Traditional Health Practitioners Act No 22 (2007) is masked by the words “traditional medicines communicated from ancestors to descendants and without written documentation”; empty clichés that have no legal standing as the truth.18

The fact is that the traditional fraternity arrived on the scene in 2007 with the Traditional Health Practitioners Act No 22 without any proof of an existing history and culture of traditional medicines to demonstrate. Claims of intellectual and property rights to traditional medicines are myths that had become truth inside a new policy of political correctness that no-one may dare challenge, like many other false cultural, social and political claims. Notwithstanding this embargo on the truth, various writers have refused to be silenced and classify the traditional healer of South Africa’s “medicines” under the single name muti. It is well demonstrated that this muti can include substances varying from human organs, human blood and nail-clippings to potions containing herbs and plants.19

A literature guideline on a South African traditional medicine culture

Other literature on traditional medicines also classified the traditional “medicines” of the South African traditional healer as pre-modern, “indigenous concoctions” that include rare lizard fat, snake skin, sun burnt beetles and spiders, lion lard, dried crocodile liver and baboon testicles and substances from plants. These are clearly not medicines that are likely to be listed and protected by the South African health authorities as exclusive traditional health intellectual property or used by the regulated health professionals.8,22,23

On the other side of the spectrum, there are undoubtedly the traditional medicines (also known as real traditional medicines or complementary-supplementary medicines) of the complementary manufacturers. They have their own standard of quality control apart from the Medicines Control Council (MCC). This is quite different from the traditional products (also named medical concoctions, magic medicines or muthi medicines) of the traditional healer that carries no assurance of quality or scientific standards. It is clear that the descriptions “of the Traditional Health Practitioners Act No 22 (2007) of what traditional medicine is” are misleading and incorrect. The definition traditional medicines of the Traditional Health Practitioners Act (No 22, 2007) means utmost unscientific and untested traditional products (or medical concoctions or mutis).8,17,24

A critical analysis of the pharmaceutical safety of these traditional products shows that the safeguard of the Traditional Health Practitioners Act No 22’s definition of traditional medicine “does not include dependence-producing or dangerous substances or drugs” is not a guarantee that the traditional healer’s present, untested traditional products (also referred to as muti, mixtures or concoctions) are free from dangerous components. These traditional products have no MCC certification and are not listed on the Pharmaceutical Product Index (NAPPI) that serves as the only guideline for pharmacists and doctors for prescriptions. The danger of these traditional products is further confirmed by the fact that the South African government (which was also the creator of the Traditional Health Practitioners Act No 22) had to establish two official centres to combat muti poisoning.8,11,25
The traditional healer and his uses of pre-modern traditional products

There is a misconception that the two entities, traditional healer and traditional medicines (in practice and real life a sub-division of supplementary medicines) are an inseparable close-knit unit in the traditional healthcare setup. To the contrary, traditional medicines are entities with their own domain, totally separate and independent from the traditional healer and his pre-modern doings and products. In addition, is it clear that the traditional healer is indeed dependent on his pre-modern traditional products for his existence as a supernatural healer? The traditional products of the traditional healer per se are pre-modern, supernatural: they can clearly not be included in the definition of modern-day traditional medicines.6,17,24

The pre-modern traditional products (specifically identified in the South African literature under the names concoctions and mutis) are used by traditional healers solely because plants and herbs (and animal substances) are plentiful, easy to gather and manufacture so-called medical products at low cost and with little know-how. There is no legislation that governs the manufacturing, use and sales of these substances. It is furthermore popular with traditional healers, plainly because traditional healers are too ‘un-trained’ and too ‘under-educated’ to understand how these regulated mixtures are manufactured, what effect they can have and little information regarding the safe prescription of regulated medicines.5,26,27

Besides the dangers they hold for human lives, traditional healers also have a negative impact on the biodiversity due to their self-manufacturing of medical products. As much as 86 per cent of the plant and animal sources of their products already manifest shortages. The use of certain herbs to treat HIV/AIDS led to serious damage to biodiversity, while the smuggling of protected plants and animals for use in traditional products is a very destroying determinant. Research also shows that 51 per cent of healers ignore plant reservations in their plant gathering. These devastating and unscrupulous effect traditional healers in South Africa have on the biodiversity is enormous if the statistics about their use and output of traditional products per annum are true and are taken into consideration. If these figures are correct, yearly 1 500 tons of medical products are sold at the Durban markets alone, 20 000 tons of indigenous plant materials of 771 species of plants are used, and 128 million courses of traditional medicine treatments are prescribed.10,11,17,28

The limited successful (but unconfirmed) outcomes in the use of traditional products by South African traditional healers in the treatment of various simple diseases, shows that the traditional healer does not have an extraordinary healing ability with the exclusive use of his self-made traditional medical products. Real traditional medicines do have potential, but then clearly apart from the traditional healer’s pre-modern manufacturing and use of his traditional products. Traditional medical products’ only contribution in the past and still today, is that as “spiritual medicines” help the traditional healer to survive and to stay in the present position of supernatural and mystic treatments.9,26,27

Real traditional (complementary) medicines of the SMASA, HPA and TMSC

In essence, “real” traditional medicines, which are associated with, and are similar too, or are part of supplementary/alternative medicines, are nothing else than natural or phyto-medicines, meaning medicines made from plants. Modern medicine in South Africa does have branches in the use of herbs and plants, like the naturopathy, homeopathy and phytotherapy. Even the modern medical practitioner makes use of these types of real traditional medicines in the refined medicines used by him, seeing that as much as 30 per cent of the world’s collection of drugs comes from plants, but only after they are reworked and refined pharmaceutically and scientifically. In the modern medical practice, these real traditional medicines are thus verified by scientific cause-and-effect guarantees, based on reworking and refining, and biochemical tests and retests before they are allowed to be prescribed. This is far removed from the pre-modern traditional products, described wrongly in Section 1 of the Traditional Health Practitioners Act No 22 (2007) as traditional medicines, together with the traditional healer’s refusal to put his primitive, self-made traditional products (mutis or concoctions) on trial for testing and retesting and to obtain scientific certification to ensure their safety for use.5,16,22,27,29

The good standing of real traditional medicines as future modern medicines in South Africa – but far removed from the traditional healers’ backstreet manufacturing and use of traditional products – is well reflected by its research in the private pharmaceutical fraternity to develop it into scientific, accountable medicines. Various bodies have worked to legalize supplementary medicines (original real traditional medicines) over the years, like the Self-
Medication Manufacturers of South Africa (SMASA), the Health Products Association (HPA) and the Traditional Medicines Stakeholders Committee (TMSCo).6,29-32

The role of the HPA in offering complementary (real traditional) medicines, separated from the traditional healers’ pre-modern products, must be highlighted here to show the immense difference between “real” traditional medicines and pre-modern traditional mixtures. This encircling Association (formed in 1975 by 114 manufacturers, importers and distributors of complementary medicines and health products), is part of the modern traditional medicines fraternity that totally excludes the traditional healer and his self-manufactured traditional products (also generally known as mutis and concoctions). These 114 companies cover most of the market for supplementary medicines and include the largest individual companies in South Africa. This group generates a conservative turnover of R 7 to R 8 billion in revenue per year. The HPA is also a member of the European Federation of Associations of Health Products (EFAHP).6,29-32

Governmental input to real traditional medicines

The South African government itself shows a keen interest in real traditional medicines, and is steering comprehensive input into the development of real traditional medicines through collaboration with various parastatal government bodies. This is in collaboration with the Medical Research Council (MRC) and its Traditional Medicines Research Unit (TMRU) that works with universities, the Council for Scientific and Industrial Research (CSIR) and its Institute for African Traditional Medicines (IATM). These bodies are completely independent from the South African traditional healers or the supplementary health industry.6,16,33

The aim of the last mentioned institute (IATM) is to screen most of South Africa’s more or less 24,000 indigenous plants for biological-active components (of these plants, traditional healers use only approximately 3,000 for their mutis and traditional mixtures). The MRC and the University Cape Town (UCT) have a joint venture to create a real traditional medicines database (TRAMED111), with the aim to gather relevant research on traditional medicines. There is also the Medicines and Related Substances Control Act of 1965 (Act No 101, 1965) that empowers the Medicines Control Council (MCC) to protect the public by ensuring that all medicines that are sold, distributed and used in South Africa, are safe, effective and manufactured according to acceptable standards of quality.6,16,33

The HPA has a Self-monitoring Technical Committee (STC) that assists its members to maintain internal ethical standards of production, quality control, marketing and advertising within the industry and the market place of supplementary or developed traditional medicines in South Africa. It ensures that good manufacturing procedures are implemented by manufacturers, subject to the legislative control of the Department of Health (DOH).6,16,32-34

Regarding the guardianship and management of real traditional medicines (including plants and herbs), the South Africa National Biodiversity Institute (SANBI) was founded to ensure that indigenous knowledge is protected and that the material and scientific benefit that may come from indigenous knowledge, are shared with communities where applicable, but clearly not specifically the traditional healers.6

Discussion

Researchers35,36 are correct when they say that the growing international popularity of traditional medicines signals also a new era for traditional medicines in South Africa, but go astray when they see traditional medicines as the same as mutis or traditional pre-modern medical products, and the traditional healer as the primary role player in this setup. Indeed, the traditional healer is not even a secondary role player. The traditional healer’s negative role and his medical products outweigh any advantages and benefits to scientific medicines know-how. His traditional products are undoubtedly potential health dangers to the public.

It is clear that the real South African traditional medicines are being taken care of by various public and private pharmaceutical and scientific institutions and other entities in their focus to develop most of the real traditional medicines into a pharmacopoeia and sound modern medicines and to inaugurate them into the South African user bank of modern medicines. This inclination is far removed from the traditional healer and his pre-modern, supernatural practices, beliefs, habits, customs and dangerous medications. It re-affirms that real traditional medicines are not owned at all by the traditional healers of South Africa.37
**Strength and limitations**

The study successfully reflects on the misleading viewpoint that South African traditional medicines are the same as the so called traditional medical products of the South African traditional healer and that the traditional healer is the owner and manufacturer of traditional medicines in South Africa.

There is a lack of interest to promote the true role players in the manufacturing of South African traditional medicines and efforts to better the public’s understanding of what traditional medicines are. Such support would surely strengthen the findings of this research.

**Conclusion**

First, real traditional medicines are clearly not the South African traditional healer’s exclusive property and right to use alone. It belongs to all the peoples of South Africa and all registered health practitioners that are allowed to prescribe medicine to the public and the private formal sector of manufacturers of medicine.

Second, there is nothing secret about real traditional medicines as the definition of *traditional philosophy* in Section 1 of the Traditional Health Practitioners Act No 22 (2007) tries to profess. Its descriptions mislead the public to see traditional medical products (mutis and traditional healer’s mixtures) as traditional medicines.18

Third, it is clear that the South African traditional healer’s substandard medical knowledge, way of practice and use of his traditional products, do not fit into the scientific scene of modern, real traditional medicines. His products are plainly, ancient and dangerous.

Fourth, the development of real traditional medicines in South Africa was undoubtedly not maintained by the traditional healers themselves over the centuries. This is confirmed by their present-day poor scientific status, untrustworthy medical know-how and potentially dangerous medical products. Indeed, their pre-modern medicine-making is devastating to the South African biodiversity and a danger to the public.

Fifth, the title deed of the ownership of traditional medicines, with or without the prefix real, is held by various public and private entities, including pharmaceutical and scientific institutions, totally outside the domain of the South African traditional healing fraternity.

So, next time when the South African traditional healer cries blue murder about his alleged ownership of traditional medicines, just ask him for his “card and transport”.

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ADDENDUM B5:

PUBLISHED ARTICLE 10

(CHapter 2)

ESTIMATED ANNUAL INCOMES OF SOUTH AFRICAN TRADITIONAL HEALERS AS GENERATED BY THEIR PRACTICES AND SALES OF THEIR PRE-MODERN TRADITIONAL PRODUCTS FOR 2015/2016


[Archives Australasian Medical Journal; Vol. 10 (2017), No. 2: Estimated annual incomes of South African traditional healers as generated by their practices and sales of their pre-modern traditional products for 2015/2016]
Estimated annual incomes of South African traditional healers as generated by their practices and sales of their pre-modern traditional health products for 2015/2016

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ABSTRACT

Background

In South Africa, it is an accepted fact that the main role players in the manufacturing and selling of so called traditional medicine (TAM) are traditional healers. The Traditional Health Practitioners Act No 22 not only strengthened this perception in 2007 by giving statutory recognition to traditional healers as traditional health practitioners, but also with its various definitions as they are reflected in the Act.

There is an estimation that South African research on traditional healing that TAM, specifically under the guardianship of the traditional healers, generates in excess of R2 billion (R2,000 million) annually.

The idea also exists that the traditional healers offer a widespread indispensable medical service, specifically through their medical and health products, which contributes to a further R1 billion (R1,000 million) or more in income.
Aims

The study aims to estimate the annual income generated by South African traditional healers in their practices and with the manufacturing, prescription and selling of their traditional health products for the period 2015/2016.

Methods

This is an exploratory and descriptive study that makes use of an historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on the South African traditional healers’ estimated annual incomes as generated by their practices and the manufacturing, prescription and selling of their health and medical products for the period 2015/2016. The findings are offered in narrative form.

Results

Over the years, it seems that a misconception was established in South Africa about what traditional medicines really are and who the specific manufacturers and sellers are. There is no differentiation between the traditional medicines offered and marketed in the South African retail and commercial market, and those prepared by traditional healers. Some traditional medicines are available from well-established outlets like pharmacies, modern-day health shops and allied-traditional healthcare professionals like the statutory recognised homeopaths, naturopaths, phytopaths and ethnopathways. These medicines have to adhere to a formal manufacturing and scientific foundation, while traditional healers rely on self-made, pre-modern and untested indigenous mixtures. This lack in differentiation and scientific foundation has clouded the true ownership of traditional health and medical products as viewed and understood under the definition Traditional African Medicines (TAM). This vagueness also obstructs the compilation of a profile of the incomes generated by the various role players in their practices and by manufacturing and selling of traditional medical and health products. The end result is a misrepresentation of sales statistics in South African literature on traditional healers and their self-made health products and untested mixtures.

Conclusion

The present-day statistics cited in literature of annual incomes of between R2 billion (R2,000 million) and R3.4 billion (R3,400 million), roughly an average of R2.7 billion (R2,700 million), from the sales of traditional health products and mixtures by South African traditional healers, are false. What is more, South African literature generally reflects an erroneous classification of who the true manufacturers and sellers of traditional health and medical products are, and what “traditional medicines” really mean. This has led to an acceptance of South African traditional healers and their untested and risky health products and mixtures based on a misconception that they are the true manufacturers, sellers and owners of TAM.

The most prominent role player in the manufacturing and selling of traditional medicines and the true income-generator seems to be the formal South African industry of complementary/alternative medicines (CAM). This comprehensive, well-established and prominent medicines industry has been manufacturing and marketing South African traditional medicines for decades. They do this scientifically as a viable and sustainable enterprise.

In comparison, there are the traditional healers’ unscientific practices and the medical products that they manufacture and sell outside of the formal healthcare sector. There is no sound foundation and substantiated evidence in the literature to confirm their primary role as manufacturers, developers and sellers of the modern-day South African traditional medical and health products. They fail the test as scientific, viable and sustainable role players in the field of South African traditional healing and TAM.

Key Words

Comprehensive, domain, expenditure, indigenous, mutl, pre-modern

What this study adds:

1. What is known about this subject?

Few trustworthy literature and data sources are available; mostly inscrutable assumptions and statements are offered to account for the matter.
2. What new information is offered in this study?

Although the estimates of this study are based on comparisons with the incomes of the allied and allopathic health professions, a new and realistic viewpoint could be stated.

3. What are the implications for research, policy, or practice?

An in-depth study is urgently needed. The present-day income figures of South African traditional healers as reflected in literature seem to be an over-estimation.

Background

Alleged income from traditional medical products in South Africa

Literature on South African traditional healing reports extraordinary high incomes for traditional healers per se from the production and sale of traditional medicine, better-known as pre-modern health products or traditional mixtures.¹ ³

Traditional healers claim that there is an extraordinary demand for traditional healing in the form of treatment and pre-modern traditional medicines. They propose that approximately 80 per cent of South Africans regularly consult traditional healers for treatment with their traditional health medicines and that this has led to a contingent of 200,000 or more practicing traditional healers in South Africa.¹ ⁵⁻⁶

Traditional healers purport that the massive impact of their service delivery in South Africa leads to 128 million traditional prescriptions to 26.6 million customers annually. They claim that 133,000 persons work in the South African pre-modern traditional medicine trade, generating incomes worth between R2 billion (R2,000 million) and R3 billion (R3,000 million) or more per year, representing 5.6 per cent of the national health budget. They furthermore allege that 72 per cent of Black South Africans use traditional medicines as part of their daily lives. They also claim that this need is constantly growing and that all the various social and economic classes of Black South Africans use and prefer traditional medicines and products.¹ ⁵⁻⁶ A recent study on the economics of the traditional healers’ pre-modern medicines’ trade in South Africa postulates the existence of 68,000 full-time practicing traditional healers, 63,000 plant harvesters and 3,000 street vendors of traditional plant materials. The study postulates that this group generates possible annual incomes of between R2.9 billion (R2,900 million) and R3.4 billion (R3,400 million).³

Trustworthy literature on the TAM trade of South Africa is lacking. Most of the studies are old, while the more recent ones only focus on certain segments of Black South Africans and specific areas such as the Black trade in traditional medicines at markets like those in Durban and Johannesburg. An in-depth analysis shows that most of these researches used small samples of 30–400 persons, lacked applicable information-gathering methods, and generalise regarding the needs and use of traditional medicines and services by more than 45 million South Africans. There is a measure of political opportunism and subjectivity, specifically after the new political dispensation of 1994. There are benefits to being strong role players in some of these studies that promote traditional healing, masked under so-called “cultural customs and traditions”. Most of these studies fail when it comes to the requirements of statistical inference about the whole South African population from the information about their samples.³ ⁷ ⁸

Conclusions are strongly based on generalisations, assumed and estimated outcomes and the repetition of untested literature. The studies lack sound scientific research and statistical foundations to offer an in-depth view and understanding of the trade in traditional medicine for the country as a whole. It seems that some of these research approaches and justifications for the findings, presentations and estimations border on the reckless manipulation of facts to promote South African traditional healing and to suit the thinking of propagandists and politicians in new RSA. The inappropriate extrapolation of trends in healthcare politics, needs and education has undoubtedly led to ridiculous conclusions on traditional healing.³ ⁷ ⁸

What is more, there is a lack of objective identification and recognition of the legal role players responsible for the manufacturing, marketing, selling and scientific development of modern-day traditional healing practices and medicines in South Africa. The wider history of South African alternative medicines and healing is blindly ignored in the post-1994 political dispensation, specifically the role of complementary/alternative traditional medicines and statutorily recognised allied traditional healers. These include homeopaths, naturopaths, phytopaths and
ethnopath, who became the official guardians of the development and promotion of the modern-day South African traditional medicines by the 1980s. Propagandists and government supporters of the outdated South African sector traditional healing that an insignificant remnant of old African religious traditions and customs ignore the more scientifically-based field of alternative medicines.  

The post-1994 political dispensation has distorted the role of the South African traditional healers and their activities as role players in the country's healthcare sector. The new government is steering the future healthcare of new South Africa based on political opportunism, propaganda, emotional subjectivity and anti-Western healthcare models. It has distorted the role of the South African traditional healers and their activities as role players in the country’s healthcare sector in Traditional Health Practitioners Act No 22 (2007). The foundation of this Act is unsubstantiated allegations and statements offered by official sources regarding the high incomes generated by traditional healers in their practices and through sales of medical products.  

It is clear that objective and scientific approaches to data collection are needed to obtain insight into the incomes that South African traditional healers generate through their practices and sales of medical and health products. The focus of interest is specifically for the period 2015/2016.  

An objective and scientific approach is possible through an analysis of the incomes of the practices and the sales of complementary/alternative medicines (CAM) in South Africa. A comparison can be made to calculate estimated TAM-incomes for the country.  

Three informative studies have been published in this regard, although limited to 2003/2005. The studies address the costs, usage, generation of incomes and different role players in the field South African complementary/alternative medicines (CAM) based on information from the allied and the allopathic practitioners and the medical funds.  

The CAM pathway to calculate an estimated TAM income for 2015/2016 in South Africa  

In light of the lack of directive evidence and guidelines on the incomes generated by the South African traditional healers, the above CAM studies seem to be the only pathway to estimate the possible annual incomes generated by TAM; specifically in relation to the traditional healers’ practices and their pre-modern self-made mixtures and other health and medical products.  

For this study the above CAM information and directives were selected as a point of departure to determine by estimation the optimal/maximum possible income generated by TAM in 2015/2016.  

This direct transformation of data from CAM to TAM is based on the general assumption that the two industries function as a sort of dual system, assumed in general to be equal to each other: What happens in the one system theoretically also happens in the other. The only real difference it seems is that the one is official, the other unofficial.  

Such a 50:50 comparison of TAM:CAM evidence is questionable, since the traditional medicine/products fraternity only occupies 3 per cent of the marketing vehicles/selling points.  

CAM and its practitioners had already taken over the roles and positions of the South African traditional healers by the 1960’. CAM is one of the main role players in the development, management, marketing and steering of modern-day TAM in South Africa. This became officially in 1982 with the promulgation of the Allied Health Practitioners Act No 63, notwithstanding superficial efforts by politicians and propagandists of the outdated South African traditional healing sector to revive traditional healing in new RSA with the Traditional Health Practitioners Act No 22 (2007).  

Estimated CAM turnover for 2015/2016  

It must be noted that the above South African CAM studies, dated 2003/5 do not include statistics for growth in the CAM turnover up to 2016. A growth rate of 46 per cent was reported for the four-year period 1996–1999 (average of 11.5 per cent per annum), but there are no statistics to confirm if this growth remained constant from 2003–2016.  

[To obtain some guideline on statistics of other countries, an Australian study was consulted. This study on CAM sales of vitamins and dietary supplements for the period 2011–2015 reflects an average annual growth rate
of 12.6 per cent for vitamin and dietary supplements, while for herbal traditional products (products more or less similar to the pre-modern traditional health products and mixtures of the South African traditional healer) an average growth rate of only 6.4 per cent is reflected.\textsuperscript{10}

In 2014, it was postulated in South African literature - again lacking any evidence to substantiate it - that the CAM industry in South Africa can generate R8 billion (R8,000 million) per annum, indicating a total growth of R6.6 billion (R6,600 million) from the R1.4 billion (R1,400 million) of 2003. This indicates an annual growth rate of 34 per cent.

The annual South African GDP growth rate for 1993–2015 was much lower, namely only 2.97 per cent.\textsuperscript{12}

It seems as if the 2.97 per cent is an underestimation and the 34 per cent an overestimation. In an effort to offer an estimated, but balanced viewpoint within this contradiction on the possible 2015/2016 sales statistics of CAM, this study uses an annual average growth rate of 11.5 per cent, or 150 per cent (based on the 1996 to 1999 annually CAM growth rate) in total for the period 2003–2015/2016.

**Various definitions of traditional medicines**

It is important to understand what the meaning of traditional medicine is for South Africans before one can understand the issue around the possible optimal maximum income of TAM for 2015/2016 generated specifically by the South African traditional fraternity. Only after such an insight can the real role players in TAM be identified and the income matter appropriately evaluated.

Three definitions of traditional medicine are available:

- **World Health Organization (WHO) Global definition**: “Diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or to prevent illness”.\textsuperscript{2,13,14}

- **WHO Africa definition**: “The sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or social imbalance, and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally or in writing”.\textsuperscript{13–15}

- **The Traditional Health Practitioners Act No 22 (2007)**. The WHO Africa definition is more or less the same as that of the definition of the Traditional Health Practitioners Act No 22 (2007) as reflected in its description traditional philosophy, read together with the definition traditional medicine: “indigenous African techniques, principles, theories, ideologies, beliefs, opinions and customs and uses of traditional medicines communicated from ancestors to descendants or from generations to generations, with or without written documentation, whether supported by science or not, and which are generally used in traditional health practice”. In this context traditional medicine “means an object or substance used in traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness; or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-beings, but does not include a dependence-producing or dangerous substances or drug.”\textsuperscript{16}

The above definitions gives the impression that TAM is exclusively the intellectual property of the South African traditional health fraternity, including the indication that they are the true generators of an annual income varying from of R2 billion (R2,000 million) to as much as R3.4 billion (R3,400 million). This impression is strengthened by two prominent guidelines: first by the view that modern-day traditional medicine in South Africa is something distinct from CAM and must therefore be treated as an exclusive entity with exclusive health and medical products and income.\textsuperscript{2} The second guideline is the WHO interpretation that traditional medicine is a way of protecting and restoring health that existed before the arrival of modern medicine and that these approaches to health belong to the traditions of each country, handed down from generation to generation, notwithstanding that it is pre-modern, unscientific and outdated.\textsuperscript{9}

The WHO furthermore states, without offering evidence to support their inclination and classification, that CAM is not part of a country’s own traditions. In terms of above interpretation, CAM seems to be outside this TAM uniqueness, but as said, without sound arguments or facts to support it.\textsuperscript{9}
The definition of complementary medicine

South African and other global literature contradicts above “uniqueness” of TAM as an entity separated from CAM. CAM is indeed traditional medicine (TAM) in South Africa; It had incorporated and replaced “African indigenous medicines” successfully in South Africa over time. The official registration of phytotherapists (as well as homeopaths and naturopaths) as allied health substitutes for the traditional herbalists of indigenous healing are excellent examples of this transformation of TAM into CAM. The comprehensive definition of complementary medicine furthermore confirms that African traditional medicine was successfully incorporated into the supplementary health fraternity in the 1980s. TAM is indeed a limited subdivision (represented by phytotherapy, naturopathy, homeopathy) of the allied health fraternity in South Africa and is managed as such in terms of the Allied Health Practitioners Act No 63 of 1982.

This complementary medicine definition reads:

“Complementary Medicine means any substance or mixture of substances, originating from a plant, mineral or animal, which may be, but is not limited to being classified as herbal, homeopathic, ayurvedic or nutritional, used or intended to be used for or manufactured or sold for use in complementing the healing power of a human body or animal body or for which there is a claim regarding its effect in complementing the healing power of an animal or human body in the treatment, modification, alleviation or prevention of disease, abnormal physical or mental state, or the symptoms thereof in a human being, and may encompass substances or mixtures of substances used in the disciplines generally referred to as Western Herbal medicine, African Traditional medicine, traditional Chinese medicine, traditional Dutch medicine, homeopathy, ayurveda, aromatherapy and food supplementation”. The identification and classification of TAM in Africa (and thus also in South Africa) is that it is a sub-medicine, one of many, inside the greater medicine-group of CAM.

The above definition nullifies the exclusive global and African WHO definitions and the definition of the Traditional Health Practitioners Act No 22 (2007) on African traditional medicine (TAM), as well as the clause of “medicine before the arrival of modern medicine”. The definition extends the Act’s clause “traditions of each country, handed down from generation to generation,” to CAM, its practitioners and its customers are therefore full members of the South African “traditions of traditional medicine”. CAM’s traditional medicine knowledge and culture is undoubtedly, as described in the Traditional Health Practitioners Act No 22 (2007) regarding TAM, also “handed down from generation to generation.” Indeed, this CAM definition takes TAM directly into the health/medical sciences of the 20th century under the guardianship of the CAM fraternity. It modernises and strips the pre-modern African traditional medicine (TAM) of its supernatural and unscientific contents and past (the outdated remnants that politicians and propagandists of traditional healing at present try to revive in South Africa). On the other hand it also nullifies the assumed existence of a dual system, with TAM and CAM as equal, but independent role players in health care in South Africa (this immediately makes a theoretical estimation of TAM, based on CAM-findings, such as this study tries to do, questionable). Two contradictory issues arise here. Are the alleged R2 billion (R2,000 million) to R3.4 billion (R3,400 million) in annual revenue:

a) Trustworthy incomes generated by traditional healers in their practices, health and medical products and mixtures; or

b) Misleading and untrustworthy incomes, statistics hi- jacked by the traditional health fraternity and its propagandists and thus in reality the income statistics of the CAM?

TAM, as defined by the Traditional Health Practitioners Act No 22 (2007) and understood by the general public, is clearly not limited to traditional medicines exclusively manufactured, prescribed to patient/clients and sold by the South African traditional healers anymore. The most appropriate terms to describe and identify these untested health products and mixtures of the traditional healers in terms of the Traditional Health Practitioners Act No 22 (2007) should be South African indigenous or pre-modern traditional medical products, or traditional healers’ mixtures.
The true owners and manufacturers of TAM in modern-day South Africa

To obtain insight into the generation of the alleged approximately R3.4 billion in TAM, or any annual income otherwise generated by South African traditional health and medical products, it seems most appropriate, in light of the lack of data on TAM, to focus on the incomes of the CAM fraternity. The allied and allopathic professions are key role players. This data make estimated, but highly theoretical calculations and conclusions on the 2015/2016 incomes of traditional healers' fraternity possible. They can be extreme over-estimations though.11,16

Present-day TAM can be understood in terms of its definition as traditional medicines that are industrially manufactured on an extensive scale under the auspice of CAM in South Africa and that adhere to certain minimum health and safety standards. The main role player in this manufacturing is the Health Products Association (HPA). The role of the HPA in offering traditional medicine should be highlighted to show the immense difference between authentic, modern-day traditional medicines (that is classifiable as TAM), versus the low scale, mostly informal production of pre-modern and untested traditional health products or mixtures of the traditional healer that are erroneously described by the Traditional Health Practitioners Act No 22 (2007) as “traditional medicine”.4,5,13,19–21

The HPA consists of 114 manufacturers, importers and distributors of traditional (also referred to as complementary/comprehensive) medicines and healthcare products, including TAM and CAM, which are based on a sound scientific foundation. It is an important member of the modern traditional medical fraternity that excludes the South African traditional healers and their self-made mixtures and multi’s. These 114 companies cover most of the market of traditional medicines and healthcare products (TAM/CAM) and include the largest individual companies in South Africa. The HPA is also a member of the European Federation of Associations of Health Products (EFAHP). 4,5,13,19–21

Other formal and prominent role players in traditional medicines (TAM/CAM) in South Africa are the Self-medication Manufacturers of South Africa (SMASA), the Traditional Medicines Stakeholders Committee (TMSC), the Confederation of Complementary Health Associations of South Africa (COCHASA) and the South African Complementary Medicine Association (SACMA). Besides their input into scientific TAM/CAM, these various bodies also are constantly publishing new literature and clinical studies on CAM and TAM.9

The above-mentioned well-established and well-recognised South African CAM-bodies, although without formal accreditation by the Medicines Control Council (MCC) of South Africa, aim to ensure through in-house scientific research and development that their CAM (including TAM) and other health products are of a high quality and free from dangerous components. There are no such comprehensive manufacturing bodies owned by the traditional healers of South Africa.2,3,9

For the future development and benefit of South African TAM in general two official bodies exist, namely the Traditional Medicines Research Unit (TMRU) of the Medical Research Council (MRC) and the Institute for African Traditional Medicines (IATM) of the Council for Scientific and Industrial Research (CSIR). These official bodies are totally independent and not owned by or associated to any of the role players in the CAM/TAM fraternities including the traditional healers.1,2,11,21,22

The traditional healers try to assert the quality and standard of their traditional health products by conferring an unofficial Inyanga’s Pharmaceutical Codex on it. An in-depth analysis of the code only confirms the pre-modern inclination, low quality and patient health risks of their pre-modern health and medical products and mixtures.3,23

A comprehensive and sound infrastructure for the scientific manufacturing of traditional health and medical products is lacking at present. In South Africa, there are presently between five and 10 pharmaceutical manufacturers, who all lack in-depth, research standards and quality overseeing, active in some way in the manufacturing of traditional health and medical products. These groups seem to be supported by a further 50–100 laissez faire manufacturer of traditional products in the country, also lacking quality control. These products are manufactured, stored and sold mostly in unhygienic conditions. They do not conform to the pharmaceutical industry’s “Good Manufacturing Standards”, nor to the minimum standards prescribed for MCC-certification of medicines.2,23

In an effort to understand the present-day sales of so-called traditional medicines and products in South Africa, two different, but opposing role players must be taken into account:
a) traditional health practitioners, as defined and described by the Traditional Health Practitioners Act No 22 (2007), with their self-made and home-made, untested pre-modern traditional health/medical products and mixtures, versus

b) Market-dominated local CAM manufacturers and distributors of traditional medicines and products with their high standard of industrially produced, tested and evaluated medicines that adhere to the pharmaceutical industry’s Good Manufacturing Standards.

The aims of this study were: 1) to determine through estimation the South African traditional healers’ optimal incomes for 2015/2016 from their self-made traditional health/medical products and mixtures; 2) if the annual incomes as offered in literature, varying from R2 billion (R2,000 million) up to as high as R3.4 billion (R3,400 million) are correct or false; and 3) to determine the true generator of TAM. For data analysis the CAM statistics of 2003/5, adjusted with a total growth rate of 150 per cent (2005–2015) to make it applicable to 2015/2016, were used as a guideline for the theoretical calculations and estimates of the incomes of the traditional healers and their self-made pre-modern products and mixtures.

The study aims to estimate the annual income generated by South African traditional healers in their practices and with the manufacturing, prescription and selling of their health products for the period 2015/2016.

**Method**

The research was done by means of a literature review. This method entails formulating a view based on the evidence presented in literature. This approach is used in modern historical research that centres on topics about which there is little information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers and reports for the period 2013–2017, articles from 1999–2016, books for the period 1998–2013 and government documents for the period 1997–2014. These sources were consulted to offer a view on the incomes that the South African traditional healers generate in their practices and from sales of their self-manufactured health products and mixtures for the period 2015/2016.^{24,25}

This study was based on the population statistics (incomes) of all role players active in the South African health care. It meets the requirements of statistical inference to infer information about the whole population.

A twofold approach was used to make theoretical interpretations: first, calculations and conclusions were drawn in terms of the 2003/5 CAM-statistics; and second, calculations and conclusions for 2015/2016 were made in terms of a growth-compensation of 150 per cent on the 2003/5 CAM-statistics.

The findings are offered in the narrative form.

**Results**

The comparing and discussion of pre-modern traditional medicine sales in terms of CAM sales

It is important to determine the possible turnover for traditional products through CAM. We can make theoretical conclusions from this for a traditional product income profile to gain an understanding of the market for pre-modern medicines. [Note: The theoretical view is that the CAM and TAM fraternities are equals, but operate independently in a dual system. What is applicable to one can also theoretically be applicable to the other]. Such a turnover for comparison and theoretical conclusions on TAM is reflected in Table 1 on the sales of CAM and its health products (1998–2003).^{7} Only the statistics for 2003 were analysed and used for calculations to compare and to draw conclusions.

Table 1 reflects that a total amount of R68 102,000 (R68 million) worth of homeopathic medicines, R141,573,000 (R141 million) worth of herbal medicines, R11,075,000 (R11 million) worth of aromatherapy medicines, R889,066,000 (R889 million) worth of nutritional supplements and R238,550,000 (R238 million) worth of health foods were sold in 2003 in South Africa. Table 1 clearly shows that the only so-called ‘unique’ African medicine sold was African herbs to the value of R2,000,000 (R2 million). This was under 1 per cent of the total homeopathic sales, already reflecting the insignificant sales of traditional health products in South Africa. The majority of the sales were therefore from various traditional products (overwhelmingly under the classification CAM) of local or foreign origins, but clearly outside the manufacturing domain of South African pre-modern traditional products.
Furthermore, the R2 million worth of African herbs sold were not sold by traditional healers themselves, but by various modern outlets, like food stores, pharmacies, supermarkets, chain stores and toiletry discounters inside the CAM fraternity (See Table 2).

These African herbs, as indicated, were primarily marketed and manufactured by a modern and well-established complementary/alternative medicine (CAM) group, namely the HPA, with 114 members and other role players. There is also no indication in support of traditional healing that these products (herbs) were sold only to indigenous or Black South Africans in rural areas (the main working domain of the traditional healers) or for use in traditional rituals that involve traditional healers as such. These products were sold to the broad public, outside the traditional healers’ practice domain and could therefore have been used in the same way as Western and Chinese herbal preparations. This finding puts in doubt the view that traditional products and CAM can be seen as equal partners in the health market. Indeed, it seems that the traditional health products, as manufactured and marketed by the traditional healers, only occupy a fraction of the market and sales of that of CAM. The mass selling of traditional products by the CAM fraternity outside the traditional healers’ practices and markets, is in line with research that postulates that 90 per cent (89.7 per cent) of traditional products are sold outside traditional healers practices. This means that only 10 per cent of the traditional health products prescribed in the traditional healers’ practices can be traced to and associated with the traditional healers’ activities and can therefore be seen as income generators. This not only clarifies the low input and use of the traditional healer’s services and their untested home-made health and medical products, but foregrounds that TAM (excluding the traditional healers’ health and medical unscientific products and mixtures) is indeed part of the South African CAM. It also nullifies allegations that the need for the pre-modern health products of the traditional healers by Black South Africans are growing and that there are approximately 30 million users of pre-modern traditional medicines and that its sales represent 5.6 per cent of the National Health Budget.

The fact that African herbs represent only 1 per cent or R2 million of the total sales of CAM products in Table 1 emphasises the insignificant role that the untested traditional products and mixtures really play in the formal, organised CAM and TAM. One can safely assume that the traditional healers’ total sales of their medical products, marketed through their unorganized outlets and limited pre-modern practices, could be at most only 10 per cent of all the formal sales of homeopathic products and in value the same or less than the R2 million sales in African herbs for 2003. The 2015/2016 theoretical estimation can therefore be at the utmost R300 million for the traditional healers’ income.

This outcome does not support the alleged general income of between R2 billion and R3.4 billion. This R300 million outcome (a tenth of the alleged income of R3,000 million reflected in literature) seems a very acceptable, even optimal theoretical estimation for the total sales of traditional healers’ health products and mixtures for 2015/2016.

Another insight can be obtained from the sales of homeopathic products. Table 1 reflects that the total sales of homeopathic products were R68,102,000 (R68 million) in 2003/5. In terms of the growth compensation, this R68 million can be as much as R10 billion (R10,000 million) for CAM in 2015/2016. In theory, the pre-modern traditional products could also generate R68 million in terms of the 2003/5 CAM statistics, or R10 billion in 2015/2016 if the 50:50 relationship between traditional healing and CAM is true and can be accepted. As seen with the above finding of only a 10 per cent market share by the traditional healers’ health products when compared with CAM, one should be cautious of the possible 50:50 relationship. Various other factors also seem to nullify this 50:50 interpretation.

Here it must be noted that homeopathic products (TAM/CAM) include a mass of products outside the scope of the traditional healers’ health and medical self-made products. Also, these sales figures as reflected in Table 2 were achieved by means of an intensive marketing system. This R10 billion as a possible theoretical sales figure in 2015/2016 for traditional products requires further refined calculation, analysis and discussion.

The retail structure of CAM and its health products are reflected in Table 2 to provide an overview of the marketing approach of TAM versus that of CAM. Table 2 clearly shows that a total of 3,350 public outlets and selling points exist in the CAM market. This offers CAM the opportunity to sell on an aggressive scale.

Research only confirms the existence of between 300 and 400 informal and unorganised traditional product outlets (described as “muti-shops” in the literature and managed from sidewalks) for traditional healers in South Africa. There are only between five and 10 pharmaceutical manufacturers of traditional products, with a further
50–100 laissez faire manufacturers. This infrastructure is only 3 per cent of that of CAM. This low number of outlets and manufacturers undoubtedly limits the production and sales of the pre-modern traditional products and mixtures of the traditional healers in the country. It surely dramatically lowers dramatically the estimated R68 million sales of homeopathic products (CAM) for 2003/5 as equal to the traditional health products, as previously indicated. This situation surely also affects the growth compensation of R10 billion (R10,000 million) for pre-modern traditional products of the traditional healers estimated for 2015/2016. In terms of only 3 per cent against the 100 per cent marketing and sales ability of the CAM, the theoretical estimation of R68 million of 2003/5 and the R10 billion (R10,000 million) of 2015/2016 for the CAM, the sales figures for the pre-modern health products and mixtures of the traditional healers can be only R2 million for 2003/2005 and at most R0.4 billion (R400 million) for 2015/2016 respectively.

This finding of R400 million is in line with the above finding that the pre-modern traditional health products of the South African traditional healers as reflected in the sales of African herbs, can be no more than R300 million for 2015/2016. These two outcomes contradict the alleged incomes of between R2 billion (R2,000 million) and R3.4 billion (R3,400 million) as true incomes generated by the traditional healers.

Medical schemes expenditure on complementary traditional medicines

Another way to determine the possible financial impact of the traditional healers’ self-manufactured medical products on the total health care and to identify specifically the use and purchase of their self-made products by the public, is to analyse the medical schemes expenditure on CAM for 2005. The analysis specifically focused on pay-outs to dispensing allied and allopathic health professionals. Table 3 reflects this data.

Table 3 reflects that the total dispensing income (selling in the CAM practice) generated by the allied professions in 2005 was only R34,959,793 (R34 million) against the total dispensing income of R7,150,193,033 (R7 150 million) for all the registered healthcare practitioners. From this total income the pharmacists’ income was R6,381,064,777 (R6,381 million) and medical practitioners’ income was R769,128,256 (R769 million). This selling of CAM (R34 million) in practice by the allied practitioners is only 1 per cent of the dispensing income of the pharmacists and allopathic practitioners together.

Table 3 reveals that the allied professions fail to make the same financial impact by dispensing their CAM as the medical practitioners do with MCC medicines. The same can theoretically be said for traditional healers’ sales of their self-made traditional products, since it has already been indicated that the traditional healers’ health products only represent 10 per cent of the homeopathic sales and that the traditional healers marketing only represents 3 per cent of that of homeopathy. The traditional healers’ annual dispensing income for 2005 could not be R34 million or R5.1 billion in 2015/2016 as theoretically estimated for the allied professions. The assumed financial impact of R34 million by the an alleged 200,000 traditional healers in South Africa is further neutralised by evidence of fewer than 5,000 bona fide traditional healers practicing in South Africa. This finding is further supported by indications that not more than 1.4 per cent of the South African population make use of traditional healers and that there is a continuing decline in demand for the services of traditional healers since the 1990s in South Africa. This negative trend in terms of diminished demand is further aggravated by their lack of professional and organised consulting and marketing facilities, as well as medical fund backing. All these negative factors minimise the presence of traditional healers in the health care sector. This reflects an 1–3 per cent presence of traditional healers in the South African health care sector, meaning an income of not more than R1.2 million in 2005 and an income of R0.15 billion (R150 million) for 2015/2016.

When the allied professionals’ dispensing income for 2003/5 is specifically compared with the medical practitioners’ dispensing income, the discrepancy is still enormous: R769,128,256 (R769 million) for the medical practitioners compared with R34,959,793 (R34 million) for the allied professionals. This reflects only a 5 per cent allocation to the allied professionals. Above negative position of the allied professionals re-affirms the low incomes generated by the traditional healers in their practices and through sales of their pre-modern traditional health products. An income of R150 million seems to be optimal as reflected in the previous paragraph.

Indeed, the above data show that even the allied health professionals, who constitute a statutorily recognised health science group that has been regulated for more than 30 years in South Africa and who promotes themselves very strongly, can still not make significant in-roads into the general health care sector’s income set-up with their CAM alone. This is notwithstanding its well-developed scientific foundation and intensive self-marketing through pharmacists and organized points-of-sale. The South African traditional healers, with their total lack of an
established infrastructure (for instance formal consulting rooms, statutory status, medical aid-support), the constant decline in the demand for their services and their unscientific pre-modern health products and mixtures, is surely far worse off.

The maximum incomes of between R150 and R400 million for South African traditional healers per annum as reflected so far by the calculations of this study, seem at this stage to be acceptable and correct.

**Potential income of the traditional healer’s practice**

Another way to determine the financial incomes of traditional healers and their health products is to calculate their potential income. This can be calculated by looking at the income generated by consultations and the sales of their pre-modern and self-made health products and mixtures. These outcomes can be calculated by analysing the allopathic and allied practitioner’s practice incomes (see Table 3).

Table 3 reflects the benefits paid out in 2005 by medical schemes to the all regulated health practitioners as one comprehensive group. Medical doctors generated a total income (consultation and dispensing) of R4,402,206,860 (R4,402 million) against the total income of only R97,033,651 (R97 million) generated by the allied health practitioners. The allied health practitioners’ income is only 2.2 per cent of that of the medical doctors.

This reflects the unfavourable income position of the traditional healers in South Africa: it seems that they not only occupy at most 1 and 10 per cent of the health care market, but financially also only between 1 and 10 per cent of the health care sector’s income.

The above low-income dilemma of the traditional health fraternity is further pinpointed when the total income of homeopaths, naturopaths and phyotherapists (seen as similar professions as the traditional healers) of R20,645,813 (R20 million) is compared with the medical practitioners’ income of R4,402,206,860 (R4,402 million) for 2005. This comparison shows that the allied sub-group’s income is less than 0.5 per cent of the medical practitioners’ income.²

This outcome confirms again that the traditional healers are undoubtedly insignificant role players when it comes to income. They do not generate the extraordinary incomes alluded to in South African literature.

The low income of the South African traditional healers becomes more clear when the total consultation incomes of all the allied health practitioners is calculated (consultation income R62,073,868 or R62 million), compared to the consultation income (R3,633,078,604 or R3,633 million) of the medical doctors in 2005. In this case the income ratio between the allied and medical doctors is less than 1 per cent for the allied practitioners. (As already indicated in terms of dispensing income alone, the allied group only generated R34,959,793 (R34 million) compared to the medical practitioners’ dispensing income of R769,128,256 (R769 million). In this case the ratio is less than 5 per cent).

It is clear that the traditional healers, either through their services as healers or through the selling of their traditional products, do not occupy at present more than 1 per cent of the consultation market or the dispensing markets of the South African health care sector.

Another approach in calculating an estimated income for the traditional healers is the use of the allied health professions’ total incomes of 2003/5 as a guideline. The maximum total income per annum that the allied professions could generate in 2005 was not more than R97 million. Product sales produced a maximum of R34 million and consulting clearly did not generate an income of more than R62 million. Hereto the growth compensation reflects a potential total income of R14.5 billion (R14,500 million) in 2015/2016. The unorganised traditional healers could at most generate 3 per cent of that of the allied professions, which comes to an income of R3 million in 2005 and R0.4 billion (R400 million) for 2015/2016.

The above finding of R400 million is in line with the findings so far of an annual income of between R150 and R400 million for the traditional healers, not between R2,000 and R3,400 as alleged in literature.

If the consulting fees of only the homeopaths, naturopaths and phyotherapists of 2005 are calculated, the consulting income of the traditional healers would not be more than R0.6 million and the sale of their products would generate more or less R1 million, with the total practice income R1.6 million for 2005. Hereto, with the growth compensation, the total income of traditional healers for 2015/2016 can be as little as R240 million (R0.24 billion).
Although this amount of R240 million is R60 to R160 million lower than the amounts of R300 and R400 million for 2015/2016 so far calculated, is it still a good indicator that the traditional healers of South Africa do not generate alleged incomes of between R2 and R3.4 billion (R2,000 and R3,400) per annum.

**A perspective on the numbers of clients using traditional health products**

In an attempt to understand the anomalies of the arguments on the income generated from sales of South African traditional healers’ pre-modern and untested traditional products and mixtures, to the numbers or proportion/percentage of users of the traditional healers’ services and their medical products, the focus is therefore on the number of paying clients and the number of traditional healers that practise for an income.

Another allegation that goes hand-in-hand with the unsubstantiated reflection of 200,000 and more practising traditional healers in South Africa is the allegation in South African literature that 80 per cent of South Africans consult traditional healers regularly and that this includes all the social and economic levels of Black South Africans. The claim of 80 per cent utilization and a growth in this trend must be tested to obtain a perspective on the true usage (in rand value) of the traditional healers’ pre-modern traditional products. For such an evaluation various South Africa Household Surveys between 2003 and 2013 can be used effectively.  

It seems that since 1990, there has been a constant decline in the use of traditional healers in South Africa. In 2003 it was reported that 5.2 per cent of the public consulted traditional healers monthly, with a further 6 per cent of the public reporting that they seek care from a faith healer for spiritual needs. This total of 11.2 per cent means that 88.8 per cent of the total population does not make use of traditional healers at any time. This 88.8 per cent contradicts both the claim of 80 per cent usage reflected in South African literature and the claim of a growth in the usage of traditional healers.

One report stated that for 2008–2011, the use of traditional healers by Black households was only 1.4 per cent per month. Furthermore, the monthly visits to healers were very low (0.02 visits) compared to the utilization rates of public sector clinics (0.18) and hospitals (0.09). The least favoured provider to use when seeking health care was the traditional healer (0.1 per cent) compared to the private medical doctor’s high rating of 24.3 per cent. In total, 81.3 per cent of South African Black households used public health facilities first. This finding not only nullifies the alleged 80 per cent usage often quoted in the literature, but also the allegation that Blacks from the higher financially and better educated groups are using traditional healers more and more. It also contradicts the allegations that preference of the poor Black population is traditional healers and that these healers are inexpensive.

The 2013 National Household Survey reflects a preference rate of only 0.1 per cent for the traditional healer as the first choice health care practitioner against the preference rate of 21 per cent for medical practitioners. For the period 2004 to 2013, the average preference rate for traditional healers was only 0.2 per cent compared to an average preference rate of 22 per cent for medical practitioners.

An overview also reflects that of the Black households who do visit traditional healers, as many as 89.4 per cent of these visits are mostly culturally driven. This indicates that only 10.6 per cent of the visits are for some kind of medical reasons. It furthermore seems that 62 per cent of Black households use pre-modern traditional products without the services of traditional healers. This clearly indicates a further diminished income for the traditional healers. The above findings reflect that the alleged consultation rate of 80 per cent is false: Present-day use seems to vary from less than 0.5 per cent to 1.4 per cent. This is in line with earlier findings (with impact figures varying from 1 up to 10 per cent in certain cases) of this study that the incomes generated by the traditional healers in their practices and from the selling of their pre-modern traditional health products are limited. It is indeed insignificant when compared with total annual incomes of the medical doctors, even allied health practitioners.

**Discussion**

The above statistical incomes of this study are theoretical calculations, done with the single aim to offer insight obviate confusion around the present-day statements in research on the incomes generated by traditional healers and their pre-modern health products. Such a descriptive and exploratory approach is the only available solution for data collection to make up for the total lack of research and official data on the incomes of traditional healers and their medical products. This approach offers a “liberal” statistical model to test the trustworthiness of the many
allegations, assumptions, generalisations and statements on the incomes of the South African traditional healers and to make theoretical conclusions.

The final findings and outcomes of this study are not absolutes: indeed, the findings in most cases seem to be over-estimations of the income classes discussed and the numbers can be much lower for the traditional health fraternity than the income ceilings offered here. The primary aim of the study was merely to obtain an optimal profile, even if it favours the traditional healers’ incomes, in an effort to put to rest the dispute on the maximum incomes of traditional healers.

Negative factors were not considered during the above calculations. One such factor is a possible future ruling on CAM by the MCC can close down 60–80 per cent of uncertified CAM products and manufacturers. This will negatively affect the incomes of traditional healers as well. Another factor is the finding that as many as 90 per cent of the people who call themselves traditional healers may be mendacious healers by the standards of the traditional healer fraternity. This may cut the number of practising healers to fewer than 20,000, perhaps even 4,000, which can result in a significantly lower income grouping for traditional healers. What is more, the South African Statistical Services found in 2013 that the public’s preference for traditional healers was only 0.2 per cent between 2004 and 2013, compared to a 22 per cent preference rate for medical doctors (ratio 1:110). This reflects a growing decrease in the preference for traditional healers and their pre-modern traditional health care and products. Also the continuing decline in the use of the traditional healer since 1990 was not calculated.

Income from criminal actions like religious, muti- and ritual murders and the trade in human body parts by certain segments in the traditional healing fraternity was not taken into account. Income generated from harvesting protected plants and animals by many traditional healers and their co-workers (illegal incomes ignored as such by the propagandists of traditional healing in their present reflections on the incomes of the traditional healers) were also not included into this study. The same approach was followed regarding the negative impact that the Suppression of Witchcraft Act No 3 (1957) and stricter law-enforcement related to protected plants and animals has had. Decreased income due to extinction of plants and animals as result of the illegal actions of traditional healers can have an impact on their income in future.

There is a lack of research on CAM-TAM and the data transformation undertaken in this research to affirm the general research statements in the literature. Statements include claims such as that the customers of the traditional healers are 26.6 million in number, that 128 million traditional prescriptions per annum are issued to clients or that 133,000 full-time employees are working in the traditional fraternity. Indeed, these statements must be rejected.

A recent South African finding that postulates that there are 68,000 full-time practicing traditional healers with an average annual income of between R2.9 billion (R2,900 million) and R3.4 billion (R3,400 million) also be rejected as untrue by this research.

It seems further that any planter, harvester and seller of any plant material in South Africa have become self-styled “traditional healers” over the years. The common and daily practice of using and the selling natural products, like herbs, vegetables and fruits, have in the minds of certain South Africans become “health science” and “health plant industry”, viewed as a health care and ethnic culture that is unique to South Africa.

It is further clear that TAM and CAM are far more intertwined in South Africa than the traditional health fraternity, the South African authorities, politicians and propagandists promoting traditional healing, like to admit.

The view that TAM and CAM are independent equals in status and income in a 50:50 dual system is suspicious and must be rejected. Some of the South African statistics claimed by the traditional health fraternity and by certain role players in TAM seem indeed to be solely applicable to CAM. As such, they declared R2 billion (R2,000 million) to R3.4 billion (R3,700 million) as “true incomes” per annum for the South African traditional healers.

It must be noted that the manufacturing and marketing of TAM are not ignored by CAM in present-day South Africa. It is only the traditional healers and their pre-modern traditional products and mixtures, on the grounds of being unscientific and dangerous, that are ignored by CAM. TAM has been acknowledged and accepted in terms of its phytopathic, ethnotropic, homeopathic and naturopathic status as a subdivision of CAM. Within the CAM industry, with its established infrastructures and capital for development, the growth of formal TAM has so far been successful. This growth can be unlimited: indeed, true billions in rand income may be realised in the future.
But there is no place for the unscientific and untrained traditional healers and their dangerous, pre-modern health products in TAM or CAM in modern-day South Africa.1-3

The total possible maximum income of South African traditional healers as theoretically calculated and estimated in this study, seem to be between R150 million and R400 million for 2015/2016. The mean income, based on the separate five calculated incomes (R300, R400, R150, R400 and R240 million respectively), is R298 million. Even these figures (individual and average incomes) in money-value must be approached with caution, especially when read with the South African statistics finding in 2013 that the consultation of the traditional healers by the public is almost non-existent when compared with their main competitor, medical doctors. Even when compared with the allied health professions’ incomes, the traditional healers’ incomes are insignificant.1-6

It is clear that the general public, medical doctors and other statutory health care professionals must be properly informed, perhaps even educated, about the South African traditional healing fraternity and its over-stated role in the country’s financial and medical scenario.

Strengths and limitations

The study offers “liberal” theoretical estimates on the possible incomes generated by traditional healers’ practices and sales of their pre-modern health products, refuting the veracity of various present-day figures, like R3.4 billion (R3,400 million) per annum.

The lack of trustworthy statistics on the incomes generated by South African traditional healers from a source such as the South African Revenue Services limited a convincing and decisive conclusion. Such a final conclusion will evade South African research for many years to come.

Conclusion

The authors believe that the South African traditional healing fraternity generate at most an annual average income of R298 million (varying between R150 and R400 million).

This study rejects the allegation that the South African traditional healers generate an annual income of between R2 billion (R2,000 million) to R3.4 (R3,400 million), roughly an average of R2.7 billion (R2,700 million). This average estimation of R2.7 billion (R2,700 million), which is based on unsubstantiated assumptions, is nearly ten times the average estimation of R298 million found by this study, based on substantiated population statistics.1-6

The future viability and sustainability of the traditional health products and mixtures of the traditional healers and the traditional healers’ status as an independent and statutory health profession, notwithstanding their possible annual contribution of R150 million to R400 million to the GDP of South Africa, are in doubt. This doubt is further strengthened when their income data are compared with the income data of the allopathic doctors, even the allied doctors for 2015/2016. The constant decline in the need for traditional healers and their health products since 1990 strengthens this doubt.28-31

We believe that CAM, as the manufacturer and seller of scientifically developed traditional health products as health/food products and traditional medicines, outside the traditional healers’ practices and traditional mixtures, is the true generator of the TAM incomes in South Africa. This fact is erroneously reflected in various South Africa research projects and literature as the sales incomes of the traditional healers’ pre-modern traditional health products.28,31,36 The writer Farouk Araie’s warning must be taken to heart when he writes: 37p.13 “A lie can get halfway round the world before the truth gets its boots on. History teaches us that if you tell a lie big enough and often enough, it shall be believed as truth”.

The polemic around TAM indicates a lack of understanding about what it really is and who the true role players in its delivery in the new South Africa are. This misconception should be addressed thoroughly: only through sound knowledge can we obtain a well-managed and effective South African health care sector.

References


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**PEER REVIEW**

Not commissioned. Externally peer reviewed.

**CONFLICTS OF INTEREST**

The authors declare that they have no competing interests.

**FUNDING**

None
Table 1: Turnover on complementary medicines and health products (in Rand thousands)²

<table>
<thead>
<tr>
<th>Product category</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Homeopathy</strong></td>
<td>41,172</td>
<td>47,693</td>
<td>52,509</td>
<td>52,678</td>
<td>57,766</td>
<td>68,102</td>
</tr>
<tr>
<td>Homeopathic remedies</td>
<td>24,917</td>
<td>29,429</td>
<td>32,445</td>
<td>30,502</td>
<td>33,270</td>
<td>41,236</td>
</tr>
<tr>
<td>Tissue salts</td>
<td>2,216</td>
<td>2,706</td>
<td>2,631</td>
<td>3,629</td>
<td>3,742</td>
<td>4,107</td>
</tr>
<tr>
<td>Homeopathic creams</td>
<td>4,648</td>
<td>5,397</td>
<td>6,642</td>
<td>5,755</td>
<td>6,209</td>
<td>6,487</td>
</tr>
<tr>
<td>Anthroposophical medicines</td>
<td>7,100</td>
<td>7,600</td>
<td>7,910</td>
<td>9,697</td>
<td>9,327</td>
<td>9,327</td>
</tr>
<tr>
<td>Energy substances</td>
<td>2,291</td>
<td>2,561</td>
<td>2,881</td>
<td>3,094</td>
<td>5,219</td>
<td>6,946</td>
</tr>
<tr>
<td><strong>Herbal medicines</strong></td>
<td>45,862</td>
<td>65,705</td>
<td>86,733</td>
<td>111,034</td>
<td>145,252</td>
<td>141,673</td>
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<td>Western herbal medicine</td>
<td>45,593</td>
<td>65,018</td>
<td>84,967</td>
<td>107,171</td>
<td>133,609</td>
<td>129,717</td>
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<tr>
<td>Chinese herbal medicine</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3,093</td>
<td>8,592</td>
<td>7,273</td>
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<tr>
<td>Ayurveda &amp; Unani-Tibb</td>
<td>0,269</td>
<td>0,326</td>
<td>0,326</td>
<td>0,220</td>
<td>1,051</td>
<td>2,684</td>
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<td>African herbal medicine</td>
<td>-</td>
<td>0,360</td>
<td>1,440</td>
<td>0,550</td>
<td>2,000</td>
<td>2,000</td>
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<tr>
<td><strong>Aromatherapy</strong></td>
<td>3,475</td>
<td>4,711</td>
<td>6,083</td>
<td>9,928</td>
<td>11,392</td>
<td>11,075</td>
</tr>
<tr>
<td><strong>Nutritional supplements</strong></td>
<td>254,419</td>
<td>297,192</td>
<td>326,070</td>
<td>587,520</td>
<td>714,573</td>
<td>889,066</td>
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<tr>
<td>Vitamins</td>
<td>60,501</td>
<td>70,553</td>
<td>88,812</td>
<td>53,640</td>
<td>69,329</td>
<td>72,419</td>
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<tr>
<td>Minerals</td>
<td>46,506</td>
<td>47,402</td>
<td>54,080</td>
<td>45,233</td>
<td>48,543</td>
<td>62,768</td>
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<tr>
<td>Amino acids</td>
<td>4,915</td>
<td>5,835</td>
<td>6,455</td>
<td>4,707</td>
<td>4,410</td>
<td>12,437</td>
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<tr>
<td>Multivitamins</td>
<td>55,274</td>
<td>67,343</td>
<td>70,314</td>
<td>95,069</td>
<td>104,202</td>
<td>113,224</td>
</tr>
<tr>
<td>Vitamin / mineral</td>
<td>42,512</td>
<td>53,083</td>
<td>52,273</td>
<td>200,297</td>
<td>216,152</td>
<td>256,703</td>
</tr>
<tr>
<td>Vitamin combinations</td>
<td>44,712</td>
<td>52,977</td>
<td>54,137</td>
<td>180,168</td>
<td>257,919</td>
<td>338,307</td>
</tr>
<tr>
<td>Other combinations</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>8,405</td>
<td>14,018</td>
<td>33,206</td>
</tr>
<tr>
<td><strong>Foods</strong></td>
<td>1,74,212</td>
<td>240,334</td>
<td>319,179</td>
<td>208,688</td>
<td>230,042</td>
<td>238,550</td>
</tr>
<tr>
<td>Food supplements</td>
<td>58,753</td>
<td>90,461</td>
<td>126,074</td>
<td>48,914</td>
<td>59,634</td>
<td>65,259</td>
</tr>
<tr>
<td>Sports nutrition</td>
<td>21,934</td>
<td>27,272</td>
<td>32,924</td>
<td>12,109</td>
<td>17,307</td>
<td>29,846</td>
</tr>
<tr>
<td>Slimming products</td>
<td>46,269</td>
<td>58,226</td>
<td>56,863</td>
<td>49,536</td>
<td>59,798</td>
<td>47,598</td>
</tr>
<tr>
<td>Health drinks</td>
<td>24,257</td>
<td>31,216</td>
<td>64,574</td>
<td>60,507</td>
<td>43,934</td>
<td>48,670</td>
</tr>
<tr>
<td>Herbal teas</td>
<td>13,088</td>
<td>20,715</td>
<td>23,963</td>
<td>28,872</td>
<td>38,322</td>
<td>36,400</td>
</tr>
<tr>
<td><strong>Total invoiced sales revenue (excluding VAT)</strong></td>
<td>519,141</td>
<td>655,636</td>
<td>790,573</td>
<td>969,848</td>
<td>1,159,027</td>
<td>1,348,466</td>
</tr>
</tbody>
</table>

Derived: Gqaleni et al., p.185

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Table 2: Retail structure for complementary medicines

<table>
<thead>
<tr>
<th>Retail outlets</th>
<th>Number of outlets</th>
<th>% of business</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health food stores</td>
<td>250</td>
<td>20</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>2,500</td>
<td>50</td>
</tr>
<tr>
<td>Supermarkets, chain stores, toiletry discounters</td>
<td>600</td>
<td>30</td>
</tr>
</tbody>
</table>

Derived: Caldis, 1977

Table 3: Medical scheme expenditure on CAM, 2005 (in Rands) 2

<table>
<thead>
<tr>
<th>All registered schemes in 2005</th>
<th>Total benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioners</td>
<td>3,633,078,604</td>
</tr>
<tr>
<td>Complementary practitioners</td>
<td>62,073,868</td>
</tr>
<tr>
<td>Chiropractors &amp; Osteopaths</td>
<td>40,962,086</td>
</tr>
<tr>
<td>Homeopaths</td>
<td>20,617,553</td>
</tr>
<tr>
<td>Naturopaths &amp; phytotherapists</td>
<td>28,260</td>
</tr>
<tr>
<td>Therapeutic massage, aromatherapy &amp; reflexology</td>
<td>319,299</td>
</tr>
<tr>
<td>Ayurveda practitioners</td>
<td>144,662</td>
</tr>
<tr>
<td>Acupuncture &amp; Chinese medicine</td>
<td>2,008</td>
</tr>
<tr>
<td><strong>Medicines</strong></td>
<td>7,185,152,825,825</td>
</tr>
<tr>
<td>Dispensed by pharmacists</td>
<td>6,381,064,777</td>
</tr>
<tr>
<td>Dispensed by practitioners</td>
<td>769,128,256</td>
</tr>
<tr>
<td>Dispensed by allied and support professionals</td>
<td>34,959,793</td>
</tr>
<tr>
<td><strong>Total benefits</strong></td>
<td>45,620,539,398</td>
</tr>
</tbody>
</table>

Derived: Gqaleni et al., 2005, p. 183
ADDENDUM B6:

PUBLISHED ARTICLE 11

(CHAPTER 2)

DOES THE TRADITIONAL HEALER HAVE A RELIGIOUS DISTINCTIVENESS IN MODERN-DAY SOUTH AFRICA?

Does the traditional healer have a religious distinctiveness in Modern-day South Africa?

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ABSTRACT

Research alludes that the South African traditional healer is not a medical identity, but origin from the old Traditional African Religious Culture as a traditional religious-healer; a spiritual remnant from a previous, pre-modern time of living. Hereto had the New South Africa not only undergo dramatic religious, social, economical and political changes after 1994, but had already moved into new religious and cultural domains centuries ago, leaving many of its pre-modern religious and cultural beliefs, such as the traditional healer and his religious activities, totally behind. Present-day political and cultural moulding by politicians and cultural leaders with outdated thoughts and intentions, as the enforcing of Act No 22 (2007) and the re-starting of the traditional healer as a spiritual practitioner, are met more and more with resistance, aggression and even disrespect. It is thus important to research and to determine changes in South Africans religious values and styles to can see if the traditional healer has a religious distinctiveness in modern-day South Africa. The aim of the study was thus to determine if the South African traditional healer has a South African religious distinctiveness to make him unique and significant as a religious practitioner in Modern-day South Africa.

Keywords: African religion, indigenous, homo Africanus, homo Europeanist, priest, religious distinctiveness, spiritual, traditional healer.

1. Introduction and background

Some research on the status of the South African traditional healer and traditional healing, that includes research on Act No 22 (2007) and its various definitions, identify a so called exclusive religious distinctiveness to be associated with the traditional healer in the modern-day South African Society. These opinions reflect that the traditional healer is an essential and a prominent part of the religious life of Black South Africans, especially those in the poorer rural areas. This alleged religious distinctiveness stands specific in relation to their believing in the supernatural and
the evil-doings of the witch; elements which are built into Act No 22 (2007) and are seen as an exclusive part of the traditional healer’s spiritual practice (Boon, 1996; Essien, 2013; Gumede, 1990; Mbiti, 1991).

Hereto see various other researchers above assumptions, views and opinions of the role of the traditional healer in the South African society as a religious practitioner as insignificant or even as untrue. Evidence shows in total only between 1.2% and 1.5% of the population makes use of the traditional healer, while as a diviner/spiritualist his usage is only between 1% and 1.3% by the total population (Holland, 2005; Nxumalo et al, 2011; Petersen, 2013; Wilkinson, 2013).

The view that the South Africa traditional healer has a religious distinctiveness seems to be doubted and needs further evaluation.

2. The identification of the traditional healer as a religious practitioner

Comprehensive research by writers with deep roots in the African Culture and its religion customs and traditions clearly define the traditional healer as a religious practitioner, a person with a strong religious social leadership-standing in the African Society. Essien (2013) describes the traditional healer as an inextricable component of the Traditional (old) African Religions, that the act of healing by the traditional healer is divinely and that the traditional healer’s healing acts are aimed at aiding humans to adjust to superstition, magic and religious actions and threats. Gumede (1990) sees the traditional healer and his healing process as an internal part of the African Religion-setup and as a “gifted man of God”: a parallel to the modern-day religious minister and evangelist. The idiom of approach of the traditional healer for Gumede (1990) is, besides his social, political, economical and moral transformations and guidance, mainly a religious one. Boon (1996) defines particularly the work-role of the traditional healer as that of a priest-healer (meaning to heal spiritual or to restore health solely through spiritual actions).

Above classifications and identifications of the traditional healer as a priest, spiritualist, a seer and religious leader and practitioner, are supported by the descriptions and definitions of many other researchers (Cheethams & Griffiths, 1982; Griffiths & Cheethams, 1982; Gqaleni et al., 2007; Hund, 2000; Nxumalo et al, 2011; Peltzer, 2009; Rautenbach, 2014; “Religion in Africa”, 2014; “Studying Africa”, 2014; “Traditional healers of”, 2014).

Shortcomings of most of these classifications and identifications are how the traditional healer as a community religious figure/practitioner/leader represents a certain group of believers’ religious views and what his own religious learning, opinions and standpoints are. Further are there the absence of a written documentation on his doctrine and the way he is administering his religious beliefs, besides the overall acceptance that his religious healing/practice is founded in the supernatural, the ancestors and afterlife and the fighting off of the so called evil-witch. The impression is left that so many traditional religious healers/practitioners there are so many traditional religious ideologies/ dogmas are there: a grouping of unrelated and un-ordained individuals without any uniform religious practice- and belief-cohesion, customs and traditions, religious-practice buildings like churches, mosques and synagogues, congregations, a Holy Book, the Bible or Koran for religious teaching or religious training schools as commonly existing in the Islam, Christian and Hindu Religions. Act No 22 (2007) as well as its Traditional Health Practitioners Regulations No 1052 (2015) only indicate a minimum-entrance qualification to study traditional healing of Grade 3, while the training and scope of practice in the category Divination in Traditional Healing of the entity Diviner of the traditional healer is left totally undefined (Boon, 1996; Essien, 2013; Gumede, 1990; Holland, 2005; Pretorius, 1999; “Religion in Africa”, 2014; Richter, 2003; SA, 2007, 2015; Truter, 2007).

The word divination can means foreboding, forecast, fortune-telling, prediction and soothsaying, while diviner can means augur, bone-thrower, forecaster, predictor, soothsayer, witch-doctor and wizard. It is only the words divine and divinity (that form clearly nowhere part of the definitions and descriptions of Act No 22 of 2007) that can mean religion, spiritual and theology. These negative outcomes indeed put the above classification and identification of the traditional healer as a “true” or “real” religious practitioner in South Africa in doubt (Gumede, 1991; Reader’s Digest, 1993; Richter, 2003; SA, 1957, 2007).

3. Does the traditional healer really have a religious distinctiveness in Modern-day South Africa?

In light op above exclusive pointing out of the traditional healer as a religious practitioner, the question is thus: does he really has, as assumed by many researchers, a religious distinctiveness in Modern-day South Africa? The fact that only between 1% to 1.3% persons in South Africa visit the traditional healer as a religious practitioner or for spiritual rituals, together with the lack of a comprehensive written doctrine on traditional religion practices, custom and
Religion, culture, politics, economics and ethnicity are interwoven and are influencing each other daily. In under-mentioned discussions the focus will be on the interaction of these cultural, ethnic and political components on African life, specific their capture of the African Religions of pre-1900 up to today, to reflect on the presence, position and status of the traditional healer as a religious practitioner in modern-day South Africa. Only through this path of discovery it will be possible to determine if the traditional healer is a distinctive or indistinctive religious role-player in Modern-day South Africa.

The outdated Old Traditional Africa culture-religion-mould

In over viewing the role of the traditional healer in the South African religious milieu by researchers, there is the tendency to put him in relation to the Old Traditional African Cultures that are assumed still to be active today and thus is upholding the traditional healer’s religious distinctiveness. But to block-in Africa solely as ancient, isolated and captive in a Dark Age, as the Old Traditional African Religions do, is wrong and misleading. Modern-day South Africa is very modern in lifestyle, thinking and also in religious inclinations. It encompasses a wide variety of religions and although some of religious beliefs, customs and practices are seen as unique to certain areas/regions, it is in truth also shared by many Africans all over the continent. The fact that Africans were always dynamic and very adaptable to new circumstances, had contact through global economics, politics, ethnicity, modern education and communication and specific religion, brought immense changes the last 100 or more years to them. It was specific Christianity in South Africa (and Islam in the northern Africa) that became interwoven with Traditional African Religions and had changes its religious beliefs, rituals and customs (and of course, brought a vice versa change also to Christianity and Islam). Especially the similar way the monotheistic religions Christianity and Traditional African Religions had been characterized God, had made this interweaving easy (Awolalu, 1976; Boon, 1996; Gathogo, 2009; Gumede, 1990; Mbti, 1991, “Studying Africa”, 2014; “Religion in Africa”, 2014; Van Zyl, 2014).

To argue thus today that there still are thousands types/entities of religions in Africa with their own, unique, isolated and undisturbed systems and foundations of hundred years back and that they are very active in the up keep of the traditional healer’s religious status as a priest, is false. Resistance over the years to religious changes in Modern Africa seems to be minimal. Awolalu’s (1976, p. 1) argument of 40 years ago, which is still underwrote by some African policy-makers and leaders today, is outdated and is misleading to use today when he alleged that: “The declared adherents of the indigenous religion are very conservative, resisting the influence of modernism heralded by the colonial era, including the introduction of Islam, Christianity, Western education and improved medical facilities. They cherish their tradition; they worship with sincerity because their worship is quite meaningful to them; they hold tenaciously to their covenant that binds them together”.

But above Awolalu-thinking of 40 years ago is not phased-out and had found a strong position in presentday religious-political inclinations, and thus the promotion of specific uses of religious customs and habits. Present-day political and social interference and intervention by these outdated groups in the Society is plentiful; even by fundamental, small minorities with strong empowersments and influences. Indeed, this is a worldwide phenomenon and is daily reflected for instance in India, Indonesia, Israel, Iran, Malaysia, Pakistan and Syria where the religion is overstretched and captured in interaction with the politics.

Regression to old, outdated cultural thinking and doing became well-established in New Socio-political Orders. Religious recognition of a specific dogma and the upliftment as well as the up keep and promotion of itsmain executive role-player, the religious practitioner, becomes prominent, notwithstanding its minority and insignificant position in Society (Harris, 2003; Miller, 2008; Naipaul, 1998; Palkhaivala, 1994).

The same, it seems, can be said about South Africa. In the 1960s, in time of Grand Apartheid, certain aims were identified by the then leadership of the ANC to promote African Culture when they should come to power. The regulation and statutory recognition of the traditional healer with all his practice-doings like religious actions, was executed, as promised in 2007, with Act No 22 (2007); notwithstanding that he and his practice had become outdated and unacceptable for most Africans in new South Africa. As Awolalu, the present-day view and guideline of the old-time political veteran, Mr Jacob Zuma, as a prominent political opinion-maker and –executive, is also prominent, namely that the African mind, his religion and lifestyle, are (and must) functioning inside a predetermined African mould, fixed permanently many hundreds of years ago. This cementation to an outdated mindset that cannot (and may not) be changed (or had not ever changed) by the modern environment, is thus to
be expected and not a surprise. An overall free religious thinking, doing and lifestyle for the African, in terms of this fixed, outdated African view, are thus not possible. It seems, in terms of the viewpoint of Awolalu and Zuma, to be specific the African person, seated and fixed in the old (pure) cultural components, when moving out of his old African mould into the modern world society, who is losing immediately his rights to be an African or a Black (ANC, 1992, 1994a, 1994b, 1997; “JZ’s own words”, 2014; “Revolusie-meesterplan”, 2014; “Traditional healers to be”, 2016; Van Onselen, 2014a).

This in-forcing of the so called excellent qualities of traditional healing and the traditional healer as a religious practitioner, is, as already said, a priority on the mind of the ANC since the 1960s. An unquestionable must, to be accepted as true and existing. A myth became a truth for a certain group of leaders and their followers; a misleading viewpoint, also been reflected with time in the literature on the South African traditional healer’s religious distinctiveness (Boon, 1996; Essien, 2013; Gumede, 1990; Mbili, 1991; “Revolusie-meesterplan”, 2014).

It is thus no surprise that these Modern Africans, moving out of this outdated and inappropriate cultural and thought mould, are negative labelled and out-casted by so called “neo-African” politicians and other old-class Africans as “Black Europeans who have swallowed the White man’s saliva” (Gumede, 1990, p. 57). A situation that forced Gumede (1990, p. 197) disheartened, to say: “I was a Native; my children were Bantu or Bantoe; my first granddaughter was a Plural; my second granddaughter was a Black. She was nearly an African but just in case she thought she was an Afrikaner, she was made a Black”.

The truth is that Europe stopped long ago to be only home to Whites; Africa is not anymore only populated by Blacks. The change is good that even the indigenous African languages (and thus culture) are only up kept at present by the unmanageable aggravating life-circumstances of South African Blacks and that it will be replaced in 50 years by a global language(s), like English (Croucamp, 2014). The same can surely be said of present-day South African religious cultures, habits and customs.

The sole fact that Gumede (1990) himself acknowledged that racial, cultural and social borders diminished long ago and that the composition of some South African families or units consist already of a Black, African, White, Afrikaners or Creole member or members, showing the outdateness of an “unique” Africa or Black religious culture that is housing religious practitioners via traditional healers.

But, still the Old African mould of Awolalu and Zuma exists in the mindsets of small but strong opinion forming groups, whom are trying constant to incarcerate even the modern African/Black to a limited, dependent cultural role in Africa. This so called “African Nationalism” clearly tries to re-enforce racism and concepts like the traditional healer’s spiritual status, while pure culture classifications (like African, Black and White) hereto are increasingly neutralized in the new South African Social Order. The line between body enhancement and genetic enhancement (that Zuma alludes is “lost” when an African developed into the Modern World) and religious beliefs, is more and more blurred (Gumede, 1990; “South Africa’s President”, 2016; “Jesus must come”, 2016; “JZ’s own words”, 2014; Mbmbe, 2014; Newman & De Lannoy, 2014; Van Onselen, 2014a; “Zuma calls for”, 2016).

Outdated racism and belittling views of races that seeks to divide and that are denying independent thinking – and thus also new, modern religious beliefs and the right to Western and other modern-day religion adherents – are insults to the indigenous African/Black of the post-1994 South Africa. Above outdated utterances by Awolalu, Zuma and “pure” African academics and politicians, are clearly remnants of thinking of the old, phased-out Traditional African Religions what people still today wrongly experience as traditions instead as religion (what they see as tradition is indeed faith, although without formal creed or sacred texts). This old, outdated religion and cultural belief-system, that seems still to function in Zuma’s thinking, is well-echoed by his remark: “As Africans, long before the arrival of religion and [the] gospel, we had our own ways of doing things (“JZ’s own words,” 2014, p. 19). Its is in this context that the traditional healer’s so called religious distinctiveness is falsely portrayed as true, especially by Act No 22 (2007).

Here, as said, is clearly an excellent example of how fixed and false cultural, political and religious exclusiveness can be used to serve the selfish political aims of leaders, to the detriment of innocent and less fortunate people in their belief-systems on religion leadership like the traditional healer (Alonge, 2014; “Jesus must come”, 2016; “South Africa’s President”, 2016; Tlhabi, 2014a; “Zuma calls for”, 2016).

African leaders, like Awolalu, Zuma and Gumede and various other leaders, lost clearly contact with the enormous religious, cultural and political changes that had taken place since the 1900s, but mostly after 1994. The same can be said about the incorrect role of the more and more phased-out positions of the traditional healer as a religious
Religion is always dynamic and growing

Religion, as culture and lifestyles, is not a permanent or an isolated phenomenon; it is dynamic and constantly influenced by other groups’ thoughts, philosophies, know-how and behaviours. For South Africa it is far more: It is about Black Africans and White Africans, African Religions and European Religions as well as White Westerners and Black Westerners and the essence of African-ness which is no longer exclusively a thing of blackness or whiteness, but of humanity and holism. It is not anymore old, pure African thinking, believing and living incarcerated in terms of the Awolalu-Zuma-Gumede-African mould (Boon, 1996; “JZ’s own words”, 2014; Malala, 2013; Mbiti, 1991; Swanepoel, 2014; Tlhabi, 2014a; Van Onselen, 2014a; “Zuma calls for”, 2016).

This stable, advancing movement, away from “old” African traditions, lifestyle and religion like the traditional healer and outdated religious beliefs, to new African (not necessary European) ones, is well described by Ndebele (2014, p. 18): “For the ‘black’ is a fabrication, a figment of history, wherein the human that he once was vanished in sacked villages and broken families that still break; swallowed up by mines and factories and farms that still swallow; disappeared in books and films that were never about him. The South Africa ‘black’ as a figment of history became a distractor and a detractor from his human value. It is time for South African ‘blacks’ to no longer put store in ‘blackness’. To continue to do so is to insist on living in a luminal space in which dreams and effort have become disentangled almost permanently. It is time that the South African ‘black’ began to appreciate the value of aspiring towards the universal and then to live in it, to become a part of it, to add to it the cumulative value of the experience of being free in the specificity of their historical circumstances, where dream and effort are inseparable. So, am I a ‘black’? I once was, but no more, am I an ‘African’? Yes, but with qualifications. Beyond the typifying singularity of the colonized ‘African’, there is no place any more for that ‘African’. Am I a ‘comrade’? Definitively not. That kind of struggle, that described ‘comrades’ is long over. Am I a ‘citizen’? Yes, although my voice and my actions have yet to be strong enough to assert their formative constitutionality. Am I a ‘human being’? Resoundingly, yes! ”

To speak thus of a pristine or a pure African and South African religion, all with “pure” African adherents (like the traditional healer and the pre-modern religious thinking and doings that accompanying him), is today impossible. As said, Christianity spread dynamically into South Africa the last 100 years and has influenced the practices of the Traditional African Religions (old ones) and contributed much too today’s Indigenous African Religions (new ones). On the other hand, the African Religions rituals, beliefs and practices have also influenced the Christian Religions rituals, beliefs and practices immensely; the outcome was that indigenous Africans start to practice more and more a New African Religion, the so-called Indigenous African Religion (an in-between), in combination with Christianity. It must further be noted that Christianity came to African long before it reached Europe. The influences of the Christian colonists and missionaries were thus only an extension of an already established Christian religion of 1,500 years in Africa. The end-result today is a synthesis or combination of indigenous and non-indigenous rituals, beliefs and practices. Therefore, the present-day indigenous African Religions can thus be described rightfully as alloys of traditional value systems, imbided by foreign religious beliefs, rituals and practices. This interaction on the South African religious spheres was of such an extent that it is imprecise even to talk today of a sole indigenous or traditional African Religion dogma per se, seeing that Christianity not also becomes a dominant African Religion (80%), but can be described as Christian African Religions, leaving behind remnants like the traditional healer and his religious inclinations (Awolalu, 1976; Gathogo, 2009; Mbiti, 1991; “Religion in Africa”, 2014; “South Africa-History”, 2014; “Studying Africa”, 2014).

Religion changes, activated by cultural, economic and political changes, did take place all over South Africa; it includes all races and not only the Blacks. Not even Whites, notwithstanding their efforts since 1652 (especially between 1948 and 1994 with legalized Apartheid), could stop their racial, religious and cultural interaction and intermixing with Blacks. This interweaving was so intense, especially after the 1950’s, that the New Christianity (the White/European Christian Religion re-instated by the colonists and missionaries the last 100 years) forms today 80% (79.9%) of the total South African population religious inclination. The so-called belief of a separate White Christianity versus a separate Black Christianity, fails to survive. African Christianity spreads into the total South African lifestyle, phasing-out outdated and pre-modern religious beliefs in which the traditional healer previously seems to function as a religious figure (Gumede, 1990; Ndebele, 2014; “South Africa – History”, 2014).
Pobee (2001) is thus more than justified when he alludes that the homo Africanus of today is a multi-headed hydra. For him the Caucasians of South Africa is as much African as the Blacks south of the equator. The multi-headed homo Africanus and multi-headed homo Europeanist have changed South Africa and were themselves been changed. These changes go much deeper; the indigenous African is not only today a homo Africanus, but also a homo Modernist. He is in some cases much more homo Europeanist then his White counterpart and lives it fully out in his daily life, especially modern religion beliefs and -adherence that exclude the supernatural and thus the traditional healer as a needed spiritualist (Boon, 1996; Ndebele, 2014; Pobee, 2001). Today the White yuppie of the city indeed has more in common with the Black yuppie of the city than that the White yuppie does have with his White counterpart in the rural areas (Louw, 1984).

The role of religious changes in the out casting of the traditional healer in Modern-day South Africa

In terms of enormous changes in religious orientations in South Africa which have also a direct influence on the traditional role of the traditional healer as a religious practitioner, the question is also here again, namely what is the traditional healer’s role or capacity in the present-day religious setup? Obvious, it seems that his activities are located at most in the African Religions that can be divided in two groups, namely the Traditional African Religions (the old group, with little religious standing in today’s society and reflects remnants like the traditional healer as a religious practitioner) and the Indigenous African Religions (the new group, but also with a diminutive role in South Africa) that adapted parts of foreign and modern religions, cultural and cognitive thinking and behaviour in which the traditional healer as religious practitioner does not play a prominent role (Gathogo, 2009; Mbiti, 1991; Pobee, 2001; “Religion in Africa”, 2014; “Studying Africa”, 2014).

From above two main groups, it seems especially the Traditional African Religions that have become delegitimized by African governments because of their negative behaviour, linked to witchcraft, ritual sacrifices and other illegal characteristics and which, as a group, is in a process to be forced out of the religious systems. The continuous position of the traditional healer as a religious practitioner is clearly in difficulty in this setup. To evaluate the traditional healer’s position in this context, it is necessary first to determine today’s total adherents to African Religions (traditional and indigenous).

In-depth data of African Religious adherents is limited. The Pewforum (2012) research shows that in 2012 Traditional Religions represented 6% of the total World Religion Population. This group of 6% includes African Religions, Chinese Folk Religions, Native American Religions and Australian Aboriginal Religions. Regarding Africa Mbiti (1991, p.3) reflects the following in Table 1:

Table 1: Estimated main religions of Africa (in percentage): 1900 to 2000

<table>
<thead>
<tr>
<th>Year</th>
<th>Christianity</th>
<th>Islam</th>
<th>Indigenous African*</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900</td>
<td>9,2</td>
<td>32</td>
<td>58</td>
<td>1</td>
</tr>
<tr>
<td>1984</td>
<td>45</td>
<td>41</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>2000</td>
<td>48,4</td>
<td>41,4</td>
<td>8,9</td>
<td>1</td>
</tr>
</tbody>
</table>


From Table 1 it is clear that the followers of Indigenous African Religions (including the old Traditional African Religions) show a dramatic decline the last 100 years (a total decline of 49,9% in adherents). This decline seems to be in line with the phasing-out of the old, Traditional African Religions [the one’s Awolalu (1976) and Mbiti (1991) seem to support and which are refer in literature too as old, rigid or fossil religions with overwhelming unacceptable rituals, like witchcraft, bad magic beliefs, etc.].
Regarding a South African perspective, it is reported that at the turn of the millennium that there was in South Africa in terms of the total population an estimated 28.5% adherents to Indigenous African Religions (and animist-believers), against 68% Christians, 2% Islam and 1.5% Hinduism (“South Africa – History”, 2014).

Hereto, Pewforum (2012) reports that in 2010 the adherents of Traditional African Religions were 210,000 in South Africa, against a total population of more or less 50 million. This represents only a 0.42% of the total population. This finding shows that Traditional African Religions become more and more phased-out. This declined adherence is in line with Mbiti’s (1991) finding.

Furthermore, the 2012 South African Census (SA, 2012) reveals that in 2001, out of a 44 819 778 total population that indicated their religious adherence, 35 416 616 citizens were Blacks. With reference to their specific religion-affiliations, only so little as 124 947 Blacks registered as adherents to indigenous African Religions (A total of 801 Coloureds, 132 Whites and 22 Indians/Asians also reflect adherents to indigenous types of African religions). This means that only as little as 124 947, out of 35 416 616 Blacks, are still today adherents of the African Religions (including the Modern Indigenous African Religions). This represents only 0.35% of Blacks of the total Black population. This percentage is totally insignificant, especially the fact that more or less 80% of the country’s Blacks (as well as the total population), identify themselves with Christianity. The enormous decline in adherents to the African Religions that Mbiti (1991) identifies, also reflects very well in South Africa with above 0.35% of the 2001 census statistics as well as the Pewforum’s (2012) finding of 0.42%.

**A dislodged traditional healer in the Modern-day South Africa**

It can be assumed that very few of the 124 947 adherents are still pure believers of the Traditional African Religions (old) and of pre-modern beliefs, customs and rituals (including traditional healers as religious practitioners), which researchers use so often to profile the standing on true African Religions (Awolalu, 1976; Du Toit, 2014; Gathogo 2009; Gumede, 1990; Mbiti, 1991; Probée, 2001; SA, 2012).

Further is it clear that the traditional healer and his spiritual healing are not parts of the Modern-day African Christian Religion, but belongs exclusively to a limited role-playing in Traditional African Religions, as illustrated by a said Khoabane (2014, p. 6) when she, herself a ‘called’ one to traditional healing, confesses: “I do not like to call myself a Christian, even though I was raised as one, because my understanding of Christianity is people who believe in – and put their faith in – Jesus Christ”, and: “religion is based on the socio-psychic behavioural patterns of the group following it. My gift has taught me that how we end up following cultural religions is not by choice, but by spiritual connections”, and “one thing my gift has taught me is to connect with my God without trying to please other people or holding the Bible in public and announcing that I also pray”.

It is further clear that the traditional healer of South Africa became even dislodged from his above role as a religious practitioner or spiritualist over the years. Clearly, the New Indigenous African Religions do not have a place for him. Where he still manifested, as said, seems to be in the remnants of the Old Traditional African Religions that plays an insignificant role in Modern-day South Africa, but seems still to exist strongly in the minds of certain politicians with masked agendas. The traditional healer’s impact, even in the modern-day Indigenous African Religions, is minimal, seeing that even this group only represents between 0.35% and 0.42% of the religious believers of the total Black population (35 416 616). The traditional healer’s total input as a religious practitioner of only between a 1% and 1.3% consulting rate is also insignificant and correlates further with the low 0.35% to 0.42% of adherents to Indigenous African Religions in 2001. It reaffirms his “outcast” position as a present-day religion practitioner; His input to the religion-life of Modern-day South Africans seems more obstructive than constructive (Petersen, 2013; SA, 2012).

From above it is clear the roles that pure African Religions (including both the traditional and indigenous groups), with the traditional healer specific as a religious practitioner, play in present-day South Africa, are minimal. Rituals, customs, practices and muthi, that can be associated with witchcraft, demons, bad magic, witches and other negative or problematic behaviours and doings by the traditional healer, seem thus more and more to become rare in global South Africa. It is specific limited to the Limpopo Province where it seems to be problematic and where the traditional healer is still very active (Mazibila, 2014a, 2014b; Roelofse, 2012; Vincent, 2008).

**4. Conclusions**

The South African traditional healer’s treatment can be in line with that of a religious practitioner or spiritualist, but is most probable that of a pre-modern indigenous welfare-caregiver. But the true status of a trained and an ordained...
priest, monk, religious minister or reverend are totally absent. The indistinctive role of the traditional healer as a religious practitioner, in terms of his status as a diviner in modern-day life of South Africans, is confirmed by the finding that his usage as a diviner is only between 1.2% and 1.5% by the total population of South Africa (50 586 757). At maximum, this usage represents only between 607 041 and 758 801 persons and is, in terms of the established religion Christianity, insignificant. Further is there also no evidence of a documented religious doctrine underwritten by the traditional healer, in the past or present (Petersen, 2013; SA, 2012).

The up keeping of the traditional healer and his so-called religious distinctiveness in South Africa, as done by Act No 22 (2007) and especially by the literature on traditional healing, seems to be political-orientated in the post-1994 setup where political leaders and opportunistic politicians, with masked agendas, misuse traditional healers as a so-called religious and cultural heritage that must be up kept. This unhealthy political-climate is also very well misused by the traditional healers themselves to advance their own interests, like Act No 22 (2007) and thus professional status. The traditional healer, with all his supernatural doings, is a pre-modern spiritual phenomenon with an ambiguous status, stretching back to Apollo’s oracles and wizards (Latif, 2010; Mbatha et al, 2012; Ritchken, 1989; SA, 1957, 2007, 2015; Stewart & Stewart, 1988).

Evidence is clear that the South African traditional healer is not a theological or religious entity as viewed and recognised in modern-day life. It seems as if the name religious practitioner, as with his misleading identity as a medical healer, had derived from a misunderstanding by early colonists and missioners about his true religious role in the pre-modern South African Society. He is at most an augur, bone-thrower, forecaster, fortune-teller, predictor, soothsayer, witch-doctor and wizard: an entity in line with Act No 22 (2007)’s definition traditional philosophy which main intentions and focuses are the supernatural that is accompanied by fearful, unexpected, unpredictable and bad life-experiences threatening everyday-life, the afterlife with the ancestors in a central role and witch-hunting and finding. It is further clear that his diviner’s practice-activities can be in terms of the mentioned definition traditional philosophy and the legal meanings of the words divination and divider inscribed into it, be in conflict with the Regulations of the Witchcraft Suppression Act No 3 of 1957 (Gumede, 1991; Reader’s Digest, 1993; Richter, 2003; SA, 1957, 2007).

With special note to the promulgation of Act No 22 (2007), together with the role of the traditional healer specific as a religious practitioner inscribed in it, it must be mentioned that religion can not and may not be factored into the law-making process (especially into the healthcare), even if it is seen as fitting and is needed by the country. South Africa has a secular Constitution, with a Bill of Rights that guarantees freedom of religion (as well as non-belief). There is also the Ethics Act (No 82, 1990) that guides the correct and good behaviour and decision-making of the Executives of the South African State. Thus, both the South African State and its government must always remain neutral in relation to religion and neither favour any specific religion or group of believers (Devenish, 2014; Jeffreys, 2014; Mthombothi 2014a; SA, 1990).

With Act No 22 (2007) the State and the ANC-government did not stay neutral: they favoured the Traditional African Religions and the traditional healer as a pre-modern religious practitioner with their official statutory regulating of him as a healthcare practitioner. They failed the Constitution and had put indigenous South Africans back into a New Apartheid (although now a religious and cultural one), where, through Act No 22 (2007) the present government (as they accused the pre-1994 Regime of doing with the Dutch Reformed Churches in Apartheid) formed an association through Act No 22 (2007) with the traditional healer as an outdated religious group. At the same time Black people is belittled and degraded in their right to think and to live religious free by certain Black leaders under the cloak of an untrue and false neo-Africanism; one that includes specific religion as prejudice and bias (Devenish, 2014; Jeffreys, 2014; “JZ’s own words”, 2014; Louw, 1984; Mthombothi, 2014a, 2014b, 2014c, 2014d, 2014e; Ndebele, 2014; Pirow, 1958; Van Onselen, 2014b).

The South African traditional healer’s assumed exclusive religious distinctiveness is non-existing in the modern-day Indigenous African Religions, the African Society or in the General South African Society. Act No 22 (2007) is clearly inapplicable and inappropriate in its aim to accommodate and to regulate an outdated and indistinctive type of a pre-modern religious-caregiver as a modern-day professional, specific inside the formal health establishment. This kind of religious-registration, if there is merit, belongs exclusively with independent religion- or church-groups, totally outside governmental regulation and relationship.
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ADDENDUM B7:

PUBLISHED ARTICLE 12

(CHapter 3)

THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) OF SOUTH AFRICA: ITS HISTORY, RESOLUTIONS AND IMPLEMENTATIONS (PART 1: HISTORY)


The Traditional Health Practitioners Act No. 22 (2007) of South Africa: Its history, resolutions and implementations in perspective (Part 1: History)

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RESEARCH


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ABSTRACT

Background
Years of South African legislation on traditional healing practices preceded the Traditional Health Practitioners Act (Act No. 22, 2007). The first laws date as far back as 1895. It seems as if the intention of the pre-1994 legislation was not to promote traditional healing practices, but to limit the power of the traditional healer.

Aims
The study aims to describe the history that came before Act No. 22 of 2007.

Methods
This is an exploratory and descriptive study in line with the modern-day historical approach of investigation and reviewing research. The emphasis is on the use of present-day documentation, like articles, books and newspapers, as primary sources to reflect on the development and promulgation of Act No. 22. The findings are offered in narrative format.
Results

Various political and legal processes can be identified as contributing to the promulgation of the Act in 2007, especially after the 1994.

Conclusion

It had taken more than 45 years of unofficial and seven years of official struggle to get Act No. 22 promulgated in 2007. Today, nearly a decade after promulgation, it has still not been fully enacted.

Key Words

Traditional healing, traditional healer, healthcare, constitution, parliament, department health

What this study adds:

1. What is known about this subject?

The history behind South African Act No. 22 (2007) has described sporadically without any in-depth analysis or discussion.

2. What new information is offered in this study?

The study offers an overview of the development of Act No. 22, identifying the most important role players in this history.

3. What are the implications for research, policy, or practice?

The article offers a basic overview of the reasons behind the promulgation and the role players that had driven it.

Background

The Traditional Health Practitioners Act No. 22 (2007) was the end product of various South African laws on traditional healing practices, starting as early as 1895. Various early stages of development can be identified in terms of legislation that had offered traditional healers limited rights of practice. With the emergence of modern healthcare services and systems, traditional healthcare in South Africa has become marginalized and has remained undeveloped as a result. The early European healthcare model, introduced unofficially in 1652 with the settlement of the Dutch in the Cape, also contributed to this marginalization by successfully stigmatizing African traditional healing in general public thinking.1-6

It is crucial to understand the history of this Act and the role players that had contributed to its promulgation if one is to understand the focus of the Act, the controversies around it and its possible future impact on healthcare.

The aim of this study is to describe the historical developments related to traditional healing in South Africa that culminated in the promulgation of Act No. 22 (2007).

Method

The research was done by means of a literature review. This method is aimed at building a viewpoint based on the available evidence as research on the subject developed over time. This approach is often used in modern historical research where there is a paucity of information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for the period 2014 to 2015, articles from 1992 to 2014, books for the period 1990 to 2013 and governmental documents covering the period 1974 to 2016. These sources enable reflection on the development and the promulgation of Act No. 22 (2007). The sources also put the thinking and opinions on traditional healing in South Africa in perspective. The research information is presented in narrative format.7-8

Results

The early legal position of the South African traditional healer

It is said that South Africa’s first official traditional healer was appointed by uShaka kaSenzangakhona (popularly called Shaka Zulu), King of the Zulus, when he allowed Nobihyania Madondo to practise unfettered and to become...
his official sangoma.\textsuperscript{6,9} Gumede\textsuperscript{6} initially regarded this event as a unique Zulu Royal Charter to practise as a diviner, but sadly had to admit that this first distinction only came after Shaka Zulu murdered all but one of Madondo’s rivals.

Traditional healers had to be licensed in the Natal Colony and the Union of South Africa between 1895 and 1981. Under White rule this early licensing was only applicable to a specific group, referred to as healing doctors, Zulu medicine-men (Izinyanga Zokwelapha, which include midwives, the Umbelethisi) and the herbalists (Izinyanga Zamakhambi). Their practices for gain were limited to their own Zulu people. The other groups (like the wizards, witches, diviners, sky-herds or heaven doctors, rainmakers, etc.) were not licensed and were prohibited from practicing for any gain.\textsuperscript{6}

The practice rights of these groups of licensed traditional healers were included in several proclamations and Acts of Parliament. The KwaZulu Act No. 6 of 1981 even determined that the provisions of other existing Acts should not be construed as derogating the KwaZulu act and its registered traditional healers. Such acts include the Homeopaths, Naturopaths, Osteopaths and Herbalists Act of 1974 (No 52), the Medical, Dental and Supplementary Health Services Professions Act of 1974 (No 56) and the Nursing Act of 1978 (No 50).\textsuperscript{6}

Early Proclamations and Acts include:\textsuperscript{6}

- Proclamation No 7 of 1895: Statutes 1845-1899;
- Act No. 21 of 1988 Section 33: Statutes 1845-1899;
- Act No. 13 of 1928: Union Statutes 1910-1947;
- Act No. 3 of 1957: Statutes 1957;
- KwaZulu Act No. 6 of 1981.

**The pre-1994 planning on traditional healthcare for South Africa**

It seems that the main driving force behind a reconsideration of the occupation of the traditional leader was, to a certain extent, the early discriminative White decisions, policies and politics related to African cultural beliefs, customs and habits, like traditional healing.\textsuperscript{1-4,6,10}

A period of deliberation between various traditional healer groups and the Department of Health (DOH) as role players resulted in the establishment of an Internal Committee for traditional healers in 1992, followed by the election of a National Steering Committee for traditional healers in 1993. From 1993 onwards, the traditional healers focused their attention on getting formal recognition for their profession from the government. However, as a result of a lack of clear guidelines to formulate policies, the National Assembly Portfolio Committee on Health, initiated an inquiry with the main focus on three issues.\textsuperscript{1-5,11-13}

These issues were\textsuperscript{1-5,11-13}

1. The desirability of a statutory council for traditional healers,
2. The recognition of medical certificates by traditional healers; and
3. The recognition of traditional healers by medical schemes.

Various public hearings on traditional health were held in the Republic in 1997 under the auspices of the Provincial Standing Committees on Health. The information obtained was drafted into a report by the National Council of Provinces. In 1998, further hearings were conducted by the Portfolio Committee on Health, with a final report in December 1998.\textsuperscript{5,11}

The following recommendations resulted:\textsuperscript{5,11-13}

1. Legal recognition of traditional healers as a health resource; and
2. An interim council to be established for the regulation of the traditional healer as a profession.\textsuperscript{5,11}
An interim period of three years (up to 2001/2002) was allowed to the Interim Council of Traditional Healers to report back to Parliament. The objective was that a permanent council would be constituted after 2001/2002 if certain conditions had been met.\textsuperscript{12-15}

The general election of 1999 ruled out any input by the Minister of Health in proposed legislation, but various meetings and workshops were still held. In September 2000, the Health Ministry gave the Department of Health (DoH) a mandate to implement the Portfolio Committee’s recommendation of establishing an Interim Council for Traditional Healers. During 2001 and 2002 the DoH held a series of road shows countrywide for traditional healers, specifically with the aim of engaging them on the matter of regulating their profession. One outcome was the formation of a forum of traditional health practitioners under the guardianship of the DoH. Its task was to consider legislative proposals and the regulation process.\textsuperscript{12-15}

It was decided then to compile a proposed Bill (Bill No 20, 2003) to regulate traditional healers in South Africa.

**Traditional Health Practitioners Bill of 2003 (No 20)**

The pre-1994 lobbying by activists and propagandists to regulate traditional healers and to offer them statutory status, was fruitful and led to the proclamation of the Traditional Health Practitioners Bill (2003), introduced in the National Assembly as a Section 76 Bill and published in Government Gazette No 24751 of 14 April 2003.\textsuperscript{12,13}

The Traditional Health Bill of 2003 clearly stated the objective of devising regulation of traditional healers. This is reflected in the *Memorandum of 2003* to the Bill (2003). The different role players since 1994 drove this goal and it was ultimately incorporated into Act No. 22 (2007).\textsuperscript{10-13}

The Bill was a first for traditional healers in South Africa, seeing that it includes all the provinces. It therefore goes much further than KwaZulu Act No. 6 of 1981. It had constitutional implications in that it focussed on the regulation of a specific South African profession (traditional healers) that had previously been unregulated. This regulation was subject to the government’s interpretation of Section 22 of the Constitution that stipulates that all citizens have the right to choose their trade, occupation or profession freely and that the practise of a trade, occupation or profession may be regulated by law. The DoH, through its legal unit, was content that the Bill was not repugnant to the provisions of the Constitution.\textsuperscript{12,13,16}

At the time the DoH and the State Law Advisers were of the opinion that the Bill should be dealt with in accordance with Section 76 of the Constitution, since it fell within a functional area listed in Schedule 4 to the Constitution, namely *Health Services*.\textsuperscript{12,13,16}

It was decided that the start-up costs for the Council would be borne by the State. With the passing of time, the Council should achieve a greater degree of financial independence as more and more traditional health practitioners pay registration fees.\textsuperscript{12,13}

The Bill was based on other South African Health Acts, like those that regulate the Health Professions (Act No. 56, 1974) and the Allied Health Professions.\textsuperscript{17,18}

The Act was to be called the *Traditional Health Practitioners Act*, 2003, and would have come into operation on a date to be determined by the President by proclamation in the Gazette.\textsuperscript{12,14}

The above Bill was not proclaimed as an Act in 2003 as intended, but only in 2004. It was signed into law on 7 February 2005.\textsuperscript{11,12,19}

The Bill’s intention was to provide a regulatory framework to ensure the efficacy, safety and quality of traditional healthcare services; to provide for management and control over registration, training and conduct of traditional health practitioners, students and specified categories of traditional healthcare workers.\textsuperscript{11,19}

The Bill incorporated comprehensive descriptions, definitions and rules to make effective its implementation (if it became an active Act). It offered precise guidelines on how to establish a council and how to manage the traditional healers in terms of profession registration and rules, offences, and fees to pay. It offered a sound foundation on which traditional healers could develop their trade as a profession. However, some of the Bill’s definitions are vague. Especially controversial are the regulations that give the traditional healers certain practice rights and privileges on the same level as the existing regulated professions of the Health Professional Council of South Africa (HPCSA). The Bill also makes them full members of the health establishment. Specifically, their
competence to practise as a healthcare professional in terms of their present training and educational levels, is still a point of criticism by the accredited healthcare professionals.\textsuperscript{10,19}

The Traditional Health Practitioners Bill of 2003 was modeled on first-world health legislation applicable to and meant for the start-up of a well-established and well-organized profession, one with existing excellent management styles, learning programmes, a training model, and one that already has some kind of official recognition. Traditional healers did not meet these prerequisites in 2003.

**Traditional Health Practitioners Act No. 35 of 2004**

Act No. 35 of 2004, signed into law on 7 February 2005, was based on the Bill of 2003, with a few new inscriptions to make the Act's contents more clear and precise.\textsuperscript{12,13,19}

This Act was put on the shelf for a short time after the Constitutional Court ruled, after intervention by the Doctors for Life (DFL), that the Act be returned to Parliament, as it was improperly processed by the National Council of Provinces (NCOP). The Act was further opposed by the DFL as they argued that a medical practice that is not based on the allopathic system is potentially harmful to the public and can only lead to a waste of their money.\textsuperscript{11,20-23}

**Traditional Health Practitioners Act No. 22 of 2007**

After the government re-traced their steps and held public meetings in all provinces in 2007, the Traditional Health Practitioners Bill of 2007 (Bill 20 of 2007) was approved and the Traditional Health Practitioners Act of 2007 (No 22 of 2007) was signed into law in 2008. Act No. 22 (2007) was precisely the same in content as Act No. 35 (2004).\textsuperscript{10,19}

**Discussion**

The primary intention of Act No. 22 (2007) is to regulate traditional healers and to establish an Interim Traditional Health Practitioners Council.\textsuperscript{10,24}

It took 11 years of parliamentary struggle and 45 years of informal agitation from 1969 to reach the inauguration of the Interim Council in 2013.

The reason why the establishment of the Interim Council was delayed from 2003 to 2013 is unclear. It is problematic to attribute it to the modern Western medical sector of the country, as post-1994 politicians try to do, seeing that the Medical Association of South Africa (MASA) had as early as 1995 offered written guidelines for cooperation between modern and traditional healers. It rather seems as if the in-fights among the 100 or more traditional healer organizations and the many different types of traditional healers, as well as a lack in governmental support to guide and advise them on the process, played a negative role.\textsuperscript{11,25}

Research suggests that events inside in the ANC government also played a role, for instance the expulsion of Mbeki as president of the Republic of South Africa. Mbeki, who signed the Act into law on 7 January 2008, was recalled by the ANC in 2009, leading to the resignation of the Mbeki cabinet. Thereafter, an acting Minister of Health, under the then acting President Motlanthe, was appointed. The ANC elective conference of 2009 was followed by national elections and the appointment of a new Minister of Health by the new president, president Zuma.\textsuperscript{11}

The new government did not regard the Interim Council for Traditional Health Practitioners as a priority and it was not high on the priority list of the 10-point plan of the Department of Health. This led to frustration among traditional healers, which resulted in a march to the Union Buildings in Pretoria in 2011. In a petition the traditional healers raised various points of dissatisfaction. They alleged that they were treated badly by the Minister of Health and that there was lack of official action to activate the Interim Council. It was only in December 2011 that the National Department of Health took action and opened nominations for seats on the Interim Council-to-be. Health spokesperson Joe Maila informed the public and traditional healers in the media in October 2012 that the DoH aimed to have the Council up and running by the end of 2012. The Council was eventually inaugurated on 12 February 2013, while the formal establishment of the Council took place on 1 May 2014 by President Jacob Zuma in terms of Section 52 of Act No. 22 (2007). A period of three years (up to 2016/2017) was prescribed for the Council to become operative and to report back to the Minister of Health.\textsuperscript{11,21,23,26-29}
Strength and limitations

The study makes a contribution to an understanding of the intentions of the Act, where it comes from and the various role players in its promulgation.

This is vital considering the fact that Act No. 22 (2007) is a controversial Act that clearly elicits negative reaction from the established healthcare fraternity.

The fact that the Act has not been fully enacted at this stage puts a limitation on the evaluation and discussion of its practical efficiency.

Conclusion

It is clear that Act No. 22 (2007) is still, in 2016, nearly a decade after its promulgation, not functioning fully and that it is beset with many shortcomings and inexplicit definitions and descriptions. Although some of these shortcomings have in the meantime been corrected in 2015 with amendments to the Act by the promulgation of Regulations No 1052, further correction is needed to make it work effectively. If one considers the history of the Act, is seems that much more time may well elapse before it becomes functional.30,31

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(CHAPTER 3)

THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) OF SOUTH AFRICA: ITS HISTORY, RESOLUTIONS AND IMPLEMENTATIONS (PART 2: RESOLUTIONS)


[Archives Australasian Medical Journal; Vol. 9 (2016), No. 11: The Traditional Health Practitioners Act No 22 (2007) of South Africa: Its history, resolutions and implementations (Part 2: Resolutions)]
The traditional health practitioners Act No 22 (2007) of South Africa: Its history, resolutions and implementation in perspective (Part 2: Resolutions)

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ABSTRACT

Background

Before the promulgation of the Traditional Health Practitioners Act No 22 (2007), there was no formal guideline or training culture to steer traditional healing in South Africa. Training was and is still mostly informal. Sometimes a new healer is trained by other traditional healers. In many cases, the traditional healer is self-taught without any learning whatsoever.

Aims

The present study aims to describe the various resolutions of the Act to plan, develop and manage traditional healthcare training in the future.

Methods

This is an exploratory and descriptive study in line with the modern historical approach of investigation and review. The emphasis is on using contemporary documentation, like articles, books and newspapers, as primary resources to reflect on the development and promulgation of the Traditional Health Practitioners Act No 22 (2007). The findings are offered in a narrative format.
Results

It seems that Act No 22 (2007) was promulgated without comprehensive research and in-depth discussion on training with all the role players who have a vested interest.

Conclusion

It is clear that training ideals such as formal study programmes, qualified staff and institutional bodies to train and to educate future traditional healers are not immediately attainable. The nearly ten years of minimal activity to enact Act No 22 since its promulgation confirms this failure. Inexpensive and uncomplicated training paths are needed until a system can be developed. One such path is the continuation of informal in-house training with another traditional healer.

Key Words

Accredited training, educational authority, health establishment, traditional health practitioner, statutory recognition, student-practitioner, traditional tutor or master

What this study adds:

1. What is known about this subject?

In-depth research on the resolutions (regulations) of the Traditional Health Practitioners Act No 22, notwithstanding its promulgation nearly a decade ago, is still lacking.

2. What new information is offered in this study?

The present study offers a summarized explanation of the Act’s resolutions and its future intention to manage traditional healing in South Africa.

3. What are the implications for research, policy, or practice?

It offers a pathway to address possible shortcomings.

Background

South Africa first granted traditional healers statutory recognition with Proclamation No 7 of 1895 and KwaZulu Act No 6 of 1981. These pre-1994 legal frameworks were solely aimed at regulating the activities of the traditional healer and ignored any statutory form of training (“Traditional” refers to “indigenous”. The reference in this study is to informal and unregulated medical services and medicines manufactured in general by the indigenous people of South Africa. It is in meaning similar to ethno- medicine, but this name and profession has been statutorily reserved in South Africa for persons who have obtained the five-year tertiary qualification in Ethnotherapy at the University of the Western Cape).1,2

The Traditional Health Practitioners Act (Act No 22, 2007) was promulgated to rectify this pre-1994 socio-political discrimination.

One of the purposes of Section 2(b) of the Traditional Health Practitioners Act No 22 (2007) is to provide a new approach and system for the training of traditional healers, with specific reference to the traditional health practitioner, the student-practitioner and the specialist practitioner.3

The primary aim of the Act is to regulate the practice, activities and behaviour of persons practising traditional healthcare in South Africa. In turn, for this control and management by the state, the traditional healers receive statutory status and rights as a health professionals and service providers.3 An effective learning and training model for future traditional health practitioners is a pre-requisite for the success of the Act. Theoretically, the Traditional Health Practitioners Act No 22 offers a training model as embedded in the various resolutions.

The present study describes the various resolutions of the Act to plan, develop and manage traditional healthcare training in the future.

Method

The research was done by means of a literature review. This method has the aim of formulating a viewpoint based on the evidence as it developed in literature. This approach is used in modern historical research where there is a
lack of information. The databases used were EBSCOHost, Sabinet online, and various contemporary sources like newspapers for the period 2014, articles from 1992 to 2014, books for the period 1990 to 2013 and governmental documents covering the period 1981 to 2014. These sources reflect on the resolutions of Act No 22 (2007) and the plans of the South African authorities to establish a training culture for traditional healers.\textsuperscript{4,5} The findings on the intent to establish training and education for traditional healers are offered in narrative format.

**Results**

An effective and well-structured professional body is a pre-requisite for reaching the aim of the Traditional Health Practitioners Act No 22 of establishing training for traditional healers. The central role players in this endeavour are two entities, the Council for Traditional Health Practitioners (CTHP) and its chief executive, the Registrar.\textsuperscript{3}

**Council for Traditional Health Practitioners**

The Council for Traditional Health Practitioners (CTHP) has certain aims and objectives, with the training of the traditional healer as a main goal. This mandate of the CTHP is fully reflected in various sections of the Traditional Health Practitioners Act [5(a) to 5(b), 8(2), 9(a) to 9(g), 10(1) to 10(6), 11(1) to 11(3), 12(1) to 12(7), 13(1) to 13(2), 14(1) to 14(5) and 15 to 17].\textsuperscript{3}

**Registrar’s Office**

The registrar’s office is the administrative pivot. This makes the aims and objectives of the Council a reality, especially the future registration of traditional health practitioners, student practitioners and specialist practitioners. The functions of the registrar are fully described in various sections of the Traditional Health Practitioners Act [18(1) to 18(2), 19(1) to 19(2), 20(1) to 20(3), 21(1) to 21(6), 22(1) to 22(2), 23(1) to 23(4), 24(1) to 24(4), 25, 26(1) to 26(4), 27(1) to 27(2), 28(a) to 28(c)].\textsuperscript{3}

**Act No 22 (2007): various definitions and descriptions**

Various definitions and descriptions included in Section 1 of the Traditional Health Practitioners Act make provision for a new statutorily recognized training system, especially with reference to the traditional practitioner, student practitioner and specialist practitioner. The definition \textit{traditional philosophy} offers a guideline for the training and education of the traditional healers in the near future.\textsuperscript{3}

Section 1 of the Act defines a learning system as part of the definition traditional health practice. The definition describes the performance of a function, activity, process or service based on the traditional philosophy. It includes the utilization of traditional medicine and traditional practice.\textsuperscript{3}

The definition \textit{traditional medicine} in Section 1 describes the specific way in which a traditional health diagnosis is delivered and patients are treated. This is meant to start on completion of the prescribed training of the traditional healer. Traditional medicine also refers to an object or substance used in traditional health practice.\textsuperscript{3}

The traditional healers to be trained in terms of above definitions of Section 1 includes the traditional health practitioner in the categories diviner, herbalist, traditional surgeon and traditional birth attendant.\textsuperscript{3}

The type of service that the traditional healer should deliver during or after training and the establishment to which he or she must deliver this service after training, are reflected in the following two definitions in Section 3, namely:\textsuperscript{3}

1. Health establishment refers to any public or private institution, facility, agency building, place or part thereof, whether the organization intends to make profit or not, that is operated or designed to provide health services.

2. Health services include in-patient or out-patient treatment, diagnostic or therapeutic interventions, nursing and rehabilitative, palliative, convalescent and preventative health services.

The adjective \textit{traditional} is omitted from the above two definitions in the Act. The two other definitions (\textit{traditional medicine} and \textit{traditional health practice}) that do include the word \textit{traditional}, create the impression of a model where traditional healers work in a parallel and separate healthcare system from the allopathic. This creates a situation where the traditional health practitioners are on one side of a divide and other regulated health professions are on the other. The traditional health practitioner’s practice is limited to only \textit{traditional activities} as part of his service and in his place of health delivery. The omission of the prefix \textit{traditional} indicates something else: full practitioner status to the traditional healer within the same health system as that of a medical doctor and therefore on the same level. It re-affirms the government’s movement towards granting traditional healers full
status as health practitioners and merging (and forcing) traditional healers into the official health sector. This intention brings a shift in the planning and management of the training of traditional healers. [3,6–16]

The above-mentioned inclusion of traditional healers in the circle of established healthcare professions is not really new. The KwaZulu Act No 6 positioned traditional leaders in this manner. This Act indeed safeguarded all the traditional healer’s exclusive practice rights and privileges from intervention and interference by the allied and allopathic practitioners in KwaZulu. [1,17]

Section 47(1) is very specific about future accredited training institutions, education authorities and traditional tutors. There is also a general reference to fees to pay for training, a register of students and the duration of programmes. The section furthermore establishes so-called minimum requirements for the curricula, the minimum standard of education, examinations, a minimum age, standards for the general education of students who want to enrol and other educational guidelines. These prescriptions are only tentative at this stage, seeing that formal, accredited training is totally absent. The proposed Traditional Health Practitioners Regulations of 2015 (No 1052) is an amendment to the Traditional Health Practitioners Act No 22. Promulgation was set for March 2016 and these regulations make Section 47(1)(e) stipulations much more focused and Act No 22 more executable. [3,18]

It is clear that Sections 47(1)(b) to 47(1)(e) will be the primary driving force behind the planning and management of the training of the traditional health practitioners, although the Act does not say this explicitly. These Sections, together with the incorporated proposed amendments of the Traditional Health Practitioners Regulations of 2015 (No 1052), read as follows:

(a) (i) The registration by the Council of students in any prescribed category of traditional health practice undergoing education or training at any accredited training institution or education authority or with any master, the fees payable in respect of such registration and the removal by the Council from the register in question of the names of such students. Fees to be paid are foreseen to be R 100.00 for the first year and then R 50.00 per year for subsequent years (Regulations No 1052, 2015: Table of Fees)

(ii) The minimum standards of education and training required of students are stipulated as a condition precedent to registration. No one may be registered as a student practitioner unless he or she has attained an ABET Level 1 educational level or equivalent (School Grade 1-3) and has in his or her possession letter of admission indicating the training or course to be done from the tutor or institution registered and accredited by the Council to provide or offer the training or the course (Regulations No 1052, 2015: Regulation 5).

(iii) The duration of the educational programme to be followed by students at an educational or training institution or with a master (Regulations No 1052, 2015: Regulations 6) will be:

(1) The Divination student must attend or undergo training for a minimum period of twelve months in which period the student practitioner must learn at least diagnosis, preparation of herbs and traditional consultation;

(2) The student herbalist must undergo training for a minimum period of twelve months during which the student must learn to identify and prepare herbs, sustainable collection of herbs and dispense herbs and consultation;

(3) The student traditional birth attendant must undergo training for a minimum period of twelve months during which the practitioner must learn issues of conception, pregnancy, delivery of a baby and pre- and post-natal care;

(4) The student traditional surgeon (circumcision) must undergo training for at least five years during which the practitioner must observe in three initiation schools and do supervised practise for two years.

(iv) The minimum requirements of the curricula and the minimum standards of education or examinations which must be maintained at every educational or training institution or by every master offering training in traditional health practice, to secure registration and recognition of the qualifications obtained under this Act;

(b) (i) The minimum age and standards of general education required of a candidate for examination for a certificate, entitling the holder thereof to registration in terms of this Act (Regulations No 1052, 2015: Regulations 7) are as follows:
1. The student for Divination and Herbalism must be at least 18 years old, and Traditional Surgeon and Traditional Birth Attendant must be at least 25 years old, to qualify for registration for a certificate entitling the holder thereof to registration in terms of the Act;

2. The student practitioner contemplated in sub-regulation

   (i) Must at least have attained the Level 1 ABET or equivalent.

   (ii) The courses of study and the training required for examinations;

   (iii) Institutions at which, or persons with whom, educational courses or training may be undertaken and any other requirements relating to such study or training;

   (iv) The registration by the Council of persons undertaking educational courses or undergoing training and the fees payable in respect of such registration. The Council must register the persons undergoing training on FORM THPA3 on payment of the fee of R500 (Regulations No 1052, 2015: Regulation 8/Table of Fees). The following categories of traditional health practice must undergo education or training at any training institution or educational authority or with any traditional healer (Regulations No 1052, 2015: Regulation 3):

      (a) Divination;

      (b) Herbalism;

      (c) Traditional birth attendant’s practice;

      (d) Traditional surgeon (circumcision) practice.

   (v) The fees payable by candidates for examinations;

   (vi) The appointment and remuneration of examiners for examinations;

   (vii) Any matter incidental to examinations or the issue of certificates by the Council;

   (viii) The nature and duration of the practical training to be completed by persons before they may be registered;

   (ix) The nature and duration of the training to be completed by a person who has obtained a qualification as a traditional health practitioner, but who is not yet registered as such, before he or she may be registered as such.

   (c) The conditions under which a registered person may practise as a traditional health practitioner or practise in any category of traditional health practice. Regarding the exemption of the pre-requisite of training an applicant who, on promulgation of these Regulations, is a Diviner, Herbalist, Traditional Birth Attendant or Traditional Surgeon may be registered as such by the registrar on the basis of the documentary proof he or she may produce to the Registrar, or on basis that the community regarded him or her to [be] a Diviner, Herbalist, Traditional Birth Attendant or Traditional Surgeon (Regulations No 1052, 2015: Regulation 10).

   (d) (i) The registration of students of traditional health practice, including the recording of particulars relating to their training and proof of the fulfilment of the requirements thereof (Regulations No 1052, 2015: Regulation 9):

      (1) The registered students must submit or cause to be submitted the log book that details the observations and procedures undergone;

      (2) The log book must be signed by the Institution or Tutor as proof of the fulfilment of the requirements for the qualification;

      (3) The student must submit the certificate of completion of the training from their Institution or Tutor to the Council.

   (ii) The health establishments or other institutions, if any, at which or the persons with whom such training may be undertaken;

   (iii) Any other matter incidental to the registration or training of students.

Regulations No 1052 (2015) provides for the formal registration of traditional health practitioners with the Council in terms of Section 21 of the Traditional Health Practitioners Act. This can be done by applying on FORM THPA1 to the registrar and paying the fee of R 200.00 (Regulation 2/Table of Fees).
Sections 47(1)(b) to 47(1)(e) of the Act and Regulations No 1052 (2015) create a basis for planning and managing the future training and education of the traditional healer. However, these legal guidelines are incomplete and lack details on planning and managing the effective training of traditional healers. The Traditional Health Practitioners Act No 22’s training guidelines and intentions need extensive description.3,18

Regarding the vision of the Traditional Health Practitioners Act No 22 (2007), namely to create a new training model for traditional healers, Section 47(b)(i) refers specific to any accredited training institution or educational authority. This undoubtedly means a formal institution that the Interim Council intends to approve and to accept as one that meets the requirements to offer training. It seems that the focus here is on a General/FTE college or some kind of tertiary institution like a South African university.1

Private and public places, for profit or not, may offer future learning

The implication of Section 47(b)(i) is that a single traditional healer tutor, or a group of traditional healer tutors, can establish a place of learning, private or public, for profit or non-profit (see also Section 1: Health establishment). This outcome of learning from a single tutor is confirmed by Regulations No 1052 (2015): Regulations 4(1)(c)(ii), 5 and 9. One crucial fact is that all such learning institutions (either run by a single person or a group), must be registered in some way with all the prescribed South African Education Authorities. The same goes for the programmes they want to offer and the education levels of their staff. Accredited institutions are defined in Section 1. It reads: “accredited institution means an institution, approved by the Council, which certifies that a person or body has the required capacity to perform the functions within the sphere of the National Quality Framework contemplated in the South African Qualifications Authority Act, 1995 (Act No. 58 of 1995)”3,18

The goal of an immediate high level of training, especially full-time training at FTE Colleges, Universities, etc. as proposed by Act No 22 (2007) are just too ambitious to become a reality at this stage. The lawmakers clearly never thought through the implications of creating this training. Developing a year-long programme (starting with research, design, compilation and writing) can take one to three years, while the registration process with the different education authorities can take another one to three years. In addition, the development and running costs of such an enterprise come into play; special programme designers must be employed to do research on the content of programmes, while the education authorities prescribe further fees for registration of qualifications on the NQF and SAQA. Finally, the institutions need infrastructure: staff, buildings, facilities (like libraries, computers, textbooks, appointment of salaried tutors, etc.). All this must uphold the prescribed standards of the education authorities.19

The standard of the programmes that the traditional healers have to complete as reflected in Regulation 6 of the Regulations No 1052 (2015) are clearly at a very low level. This negative profile is confirmed by the ABET Level 1 entrance qualification (School Grade 1-3). The so-called dynamic and high level training of the South African traditional healer alleged in the literature over the years is clearly non-existent. Regulations No 1052 (2015) reflects this matter as well.18

Ways to train the traditional healer other than the above complicated and costly approach are needed. One such a way is in-house apprenticeships.

In-house apprenticeships

Establishing the new training model for traditional healers as foreseen by the Traditional Health Practitioners Act No 22 (2007) will be costly and time-consuming. The obstacles are overwhelming.

The lawmakers themselves were clearly unsure about which avenues to follow to instate training immediately. The only options are training at formal institutions (none exist at present), or continuous training with in-house apprenticeships. Section 47 hints at this with frequent references to the registered traditional tutor as equivalent of the formal institution in terms of training [See the phrase “or with any accredited tutor”, in the various sections of 47 b(i), b(iii), b(iv)]. This inclusion surely gives the Interim Council a way out of the proposed new training model of traditional healers as intended by the Traditional Health Practitioners Act No 22 (2007). Regulations No 1052 (2015) echoes this intention of training with many references to future training by a traditional healer as a training entity on its own (Regulations 3, 4 and 9).3,18

An in-house apprenticeship, offered by a master (tutor) traditional healer for a certain period, seems to be the most obvious solution.
An accredited in-house apprenticeship (for a moratorium period) under an accredited master or tutor traditional healer is a safe and inexpensive way out of the various problems that the new training model brings. It is furthermore clear that Regulations No 1052 (2015) makes the accreditation of tutors in terms of its Regulations (Regulations: 8/Form THPA, 1/Form THPA, 3/Tables of Fees) easy. The allowance that the approximately 200,000 unregulated traditional healers can be registered immediately based on their prior learning will free the Council from immediately creating costly training and evaluation/examination facilities. This can give them time (5 to 10 years) to reorganize the present problematic situation with traditional healing training. They will be able to put formal training institution(s) and formal programme(s) in position to accommodate a new calibre of *traditional health student*, for instance one with a Grade 12 school-leaver’s certificate instead of the ABET Level 1/School Grade 1-3 as minimum entrance qualification for study. There will be time to write and implement a traditional healer’s curriculum, etc.\textsuperscript{11,18,19}

Formulations such as the registration of students “undergoing education or training with a traditional tutor” amplifies this concern in Section 47 in its Subsections (b)(i), (b)(iii) and (b)(iv). The primary requirement of the Traditional Health Practitioners Act No 22 (2007) is that such a tutor must be accredited. Although the adjective *traditional* is omitted for *traditional tutors* in Sections 47 (b)(i), (b)(ii), (b)(iii) and (b)(iv), it appears as part of the *traditional tutor* definition (Section 1). This definition prescribes that a *traditional tutor* must be a person registered in any of the prescribed categories of *traditional health practice* and who has been accredited by the Council to teach *traditional health practice* or any aspect thereof. Section 44(2) qualifies the clause *registered* with the addition “suitably qualified healer”. Sections 47(b)(i), (b)(ii), (b)(iii) and (b)(iv), however, clearly makes provision that a tutor, not necessarily a *traditional* tutor, but any tutor acceptable for the Interim Council, can be appointed.\textsuperscript{3}

Section 44(2) still leaves the possibility that a student may be trained by an unregistered traditional healer or another type of health practitioner as long as the training takes place under the supervision of a “suitably” qualified traditional health practitioner.\textsuperscript{3}

**Discussion**

The Traditional Health Practitioners Act No 22 (2007) clearly tries to fulfill its main aim, namely to establish a high standard of training for traditional healers. Certain guidelines, although vaguely described, are put in place by the Act to reach this aim. However, it is clear that these aims will take five or more years to achieve. Traditional healers lack the planning and management know-how that would make the immediate implementation of the initial training model possible.

The use of an in-house training model with registered traditional healer tutors seems to be the most obvious solution to the present training problems. Such a training model can go on undisturbed for many years. This approach can reduce development and management costs to a minimum and assure some peace, order and upkeep in traditional healthcare for the near future.

**Strengths and limitations**

The present study puts in perspective the intentions of the Act to establish training and to manage traditional healthcare and traditional healers through certain resolutions. It can serve as a guideline for future planning.

The resolutions included in this Act have not been studied adequately. The primary role players, who should understand the Act’s intentions and should manage its resolutions correctly, do not know how to bring about functionality. A study like this one is seldom consulted and has limited immediate positive impact.

**Conclusion**

South African traditional healers (as a group) have not yet passed the basic development phase of a medical science and a health profession. The aim of the CTHP to use the final stage of development of the Traditional Health Practitioners Act No 22 (2007) as a guideline for their planning and management of the training of traditional healers is too ambitious at present.

The objective of training and managing traditional health practitioners with the Traditional Health Practitioners Act No 22 (2007) is good, but the traditional healers’ lack of leadership to steer traditional healthcare training through all the steps is a serious limitation.
The complete absence of an advanced traditional health science and culture will not be easily rectified. The true enactment of the Traditional Health Practitioners Act No 22 (2007) will move at a sluggish pace for many years to come.

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(CHAPTER 3)

THE PRESENT-DAY SCOPE OF PRACTICE AND SERVICES OF THE TRADITIONAL HEALER OF SOUTH AFRICA


[Archives Australasian Medical Journal; Vol. 9 (2016), No. 12: The present-day scope of practice and services of the traditional healer of South Africa]
The present-day scope of practice and services of the traditional healer in South Africa

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ABSTRACT

Background
The scope of practice of the traditional healer in South Africa is not guided or circumscribed by any statutory mandate at present. The traditional healer’s practice and services are currently based on and driven by the supernatural and the afterlife, lacking not only a scientific foundation, but also legal constraint.

Aims
This study aimed to determine and describe the present-day scope of practice and services of the South African traditional healer.

Methods
This is an exploratory and descriptive study that makes use of an historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on the scope of practice and services of the South African traditional healer. The findings are offered in narrative form.

Results
There is no established curriculum and practice culture to serve as an evaluation and descriptive criteria for the present-day traditional healer’s scope of practice.
Conclusion

The South African traditional healer’s practice and rights are unwritten and legally unregulated, especially when viewed against in comparison with the current practice customs, traditions and rights of the South African statutorily regulated healthcare practitioners.

Key Words

Ancestral spirit, concoction, curative medicine, germ diagnosis, health system, muti, substance

What this study adds:

1. Is there information about this subject?
   There is no literature on the South Africa traditional healer’s scope of practice.

2. Does this study add new information?
   The article foregrounds the need for a professional scope of practice.

3. Does this study have implications for healthcare policy or practice?
   The traditional practitioner’s unrestricted and unlimited rights and scope of practice in South Africa endangers the lives of his patients.

Background

The definition of “scope of practice”

The “scopes of practice” of the South African statutorily registered health professions like medical practitioners, dentists, psychologists, etc. are precisely described in various South African Acts and Regulations that regulate and control them. This implies that specific training is offered to specific practitioners to qualify them so that they may make diagnoses and offer specific treatments. This ultimately leads to a precisely described scope of practice for a specific health practitioner and his group. In South Africa, the statutorily recognised health professionals jealously guard their scopes of practice; sometimes with a narrow, de-contextualized interpretation. Position statements are issued when there is a conflict of interest between healthcare groups. Transgression of the boundaries of competitors, scope of practice so that it affects their financial income or empowerment, have, in the past, led to actions in courts of law.1

The traditional healer’s scope of practice

To date, the South Africa traditional healthcare has failed to formulate an acceptable description of diagnosis, treatment and training, with the result that a written manual of the scope of practice has never seen the light. The wide variety in the types of healers, each with their own interests and agendas, various negative political issues, and in-fighting in healer groups, have muddled efforts to establish professionalism. In addition, the lack of successive self-empowerment, resulting from the absence of a model of excellent education, training, diagnosis and treatment, has frustrated the process of formulating scope of practice.1–13

Researchers with an interest in traditional healing have to some extent identified current practices of training, diagnosis and treatment among traditional healers. It is therefore possible to formulate a basic scope of practice. Again, the various kinds of healers obstruct a uniform, in-depth definition. The focus of this research is on the herbalist and diviner. In terms of the Traditional Health Practitioners Act No 22 (2007), a traditional philosophy founded in ancestral spirits and the use of traditional (spiritual) medicine, describes the basic scope of practice. In this philosophy, the healer takes a central position in a holistic and symbolic form of healing. The healer draws on the embedded beliefs that ancestors in the afterlife guide and protect, but also punish, the living, to make diagnoses and to provide treatment. Illnesses are seen as the manipulations of spirits or gods. The treatments to protect patients include traditional medical preparations and ‘traditional medicine’ to destroy the evil powers of other persons.6,12,14–20

The only theoretical “statutory mandate” available at present to make up for the above unscientific scope of practice, are the written definitions on traditional healing offered by the Traditional Health Practitioners Act No 22 (2007), as indented for the future legally described traditional health practitioner. In light of the many similarities
between the present (old) traditional healers and the future (new) traditional healers, the legal definitions traditional philosophy, traditional medicine and traditional practice are as found the Act. The act’s mandate is applicable for use as an evaluation and descriptive instrument for this study.12,18,21 This study aims to determine and describe the current scope of the practice of the South African traditional healer.21

Methods

The research was done by means of a literature review. This method entails formulating a view based on the evidence presented in the literature. This approach is used in modern historical research centring on topics about which there is little information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers and reports for the period 1988 to 2014, articles from 2007 to 2016, books for the period 1990 to 2014 and government documents for the period 2003 to 2016. These sources were consulted in an effort to reflect on the present scope of practice and services of the South African traditional healer.22,23

Results

Certain legal definitions serve as primary guidelines in describing the scope or range of the practice and services of the South African traditional healer. These definitions are discussed below.

The legal definition traditional philosophy

The single legal definition traditional philosophy encloses a complex of sub-definitions, which includes various legal descriptions, systems, actions and meanings. These sub-definitions are further explained by various specific legally defined words and phrases in terms of Section 1 of the Traditional Health Practitioners Act No 22 (2007). Elucidators are prominent, like “indigenous African techniques, principles, theories, beliefs, opinions and customs, as well as the uses of traditional medicines communicated from ancestors to descendants or from generation to generation with or without written documentation, whether supported by science or not, and which are generally used in the traditional health practice”.21

The legal definition traditional philosophy is the foundation and pivot of the 2007 legislation (Traditional Health Practitioners Act No 22, 2007). It describes in general the new profession-the traditional health practitioner. It only indirectly and in non-specifics delineates the range of the practices and services of this healer of the future and his medicines. The definition confirms the holistic approach of traditional healing. The link with the ancestors, spirits and supernatural inclinations are the points of focus.21

The definition traditional philosophy falls into two legal sub-definitions, namely traditional medicine and traditional health practice.21

Various meanings and definitions of traditional medicine

- Traditional Health Practitioners Act No 22 (2007) of South Africa

This Act defines traditional medicine as an object or substance used in the traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in humans. The law specifies that this may not include any dependence-producing or dangerous substance or drug.21

- World Health Organization (WHO)

The WHO proposes a global and an African definition for traditional medicine.

The global definition describes traditional medicine as the intention to maintain well-being and to treat, diagnose or prevent illness. It refers to diverse health practices, approaches, knowledge and beliefs that can include plant and animal matters, mineral-based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination.24,25

For Africa, specifically, the WHO deviated from its global definition with added description that traditional medicine is the sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental, or social imbalance. It further stipulates that traditional medicine exists and is maintained exclusively by practical experience and observation, handed down from generation to generation, whether verbally or in writing.24,25

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The above WHO definition for Africa is more or less in line with the legal definition contained in the Traditional Health Practitioners Act No 22 of 2007. However, it does not include the wording “contact with ancestors”. Although the WHO definition also lacks reference to scientific knowledge, healthcare research and principles as in the definition of Act No 22, the WHO global version seems to be more scientifically orientated. The discrepancy between the two WHO definitions seems to be an effort on the side of the WHO to accommodate the overall lack of scientific principles and methods and cognitive thinking in African traditional healthcare, a system that seems still to be reflecting remnants of the old African religions.\textsuperscript{26–28}

The above legal definition of traditional medicine by the Traditional Health Practitioners Act No 22 (2007) is not unanimously accepted and sanctioned by all the researchers and role players involved in South African traditional healthcare.\textsuperscript{6,16,26,29–32} Pretorius\textsuperscript{33} sees traditional medicine as formulas manufactured from various natural substances (animal, mineral and vegetable). She also alludes to the fact that traditional medicines are used for various functions, like placebos, sympathetic magic and medical value.

Holland\textsuperscript{34}, p.15 infers that traditional medicine:

- Includes medicines for every complaint and aspiration, either dug from fields and forests by individual spiritual specialists to fulfil prescriptions for their own clients, or purchased from herbalists’ shops in the cities of Africa. It is mostly of botanical matter, but it can sometimes include bio-substances like rare lizard fat, snake skin, sun burnt beetles and spiders, lion lard, dried crocodile liver and baboon testicles.
- Makes use of remedies that may be termed sympathetic magic. For instance, to ensure a good journey, the prescription is made from a root that sends out runners and therefore knows its way. It is founded on the belief that qualities can be transferred to humans, which means that a cream made of the beautifully sleek skin of the python will make the hide of cattle gleam, or that lion’s fat smeared on the arms and legs of a soldier, will make him feared by his enemies. Furthermore, to give a person security, the herbalist may administer a portion of the body of the steadfast tortoise; for swiftness, the sinew of a hare.

Besides the above definitions and descriptions,\textsuperscript{22,24,25,33,34} various other definitions imply that the healing effect of traditional medicine is negative or unsubstantiated.\textsuperscript{22,24,25,32,33,35,36} Most of these definitions imply that the healing effect of traditional medicine is negative or unsubstantiated.\textsuperscript{22,24,25,32,33,35,36}

Comparing magic medicine, muti and traditional medical mixtures with modern traditional health products

There is a very specific differentiation between traditional medicine and the traditional health products (also known as complementary-supplementary medicines and health products or real traditional medicine) of the complementary medicine manufacturers. Act No 22 erroneously defines a grouping called traditional medicine (better known as traditional medical products, which include magic medicine, muti and traditional medical concoctions). Where complementary medical products are manufactured under strict standards of quality control and qualified pharmacists, although independent from the Medicines Control Council (MCC), the traditional medical preparations made by the traditional healers themselves are manufactured with no quality standard or internal professional control.\textsuperscript{6,16,17,25,30,37–40}

Mentioned below are some of the other definitions of traditional medical preparations (also often referred to as muti), as reflected in the literature:

- Muti is black magic, voodoo medicine used by Blacks in South Africa;\textsuperscript{36}
- The most potent muti are the ones that contain human organs, harvested from the victims still alive;\textsuperscript{36}
- Human blood and body parts are essential to the preparation of muti;\textsuperscript{20}
- Muti is a potion from herbs and plants;\textsuperscript{35}
- Muti can consist of human parts that is believed to have supernatural power and that can change or alter the cause of events;\textsuperscript{35}
- Muti is sometimes consumed, but may also be carried about the person who aims to benefit from its powers or secretly smeared onto the body, clothing or included in the food of the target person;\textsuperscript{20} and

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Muti does not always involve killing: a living person’s nail clipping may be used in potions targeted at that person.20

The pharmaceutical safety of traditional medical preparations as described in the Traditional Health Practitioners Act No 22 (2007) is superficial and misleading. The legal definition of traditional medicine reads “does not include a dependence producing or dangerous substances or drugs”. The Act contains no statutory guarantees or an official MCC certification that the untested and unscientific traditional medical preparations are free from dangerous and prohibited components. The registration of these traditional preparations on the National Pharmaceutical Product Index (NAPPI), the only manual used by the South African pharmacists and doctors for the issuing of prescriptions, is not allowed. The extent of the negative effect of poisoning as a result of the use of dangerous traditional mixtures is further evidenced by the official establishment of two centres to combat mutipoisoning.16,17,24

The legal definition traditional healthcare practice, including diagnosis, as defined by the Traditional Health Practitioners Act No 22 of 2007

Various legal definitions are generated by the Traditional Health Practitioners Act No 22 (2007). Its legal definition for traditional health practice refers to the performance of a function, activity, process or service offered specifically by the traditional health practitioner. This description is, as said, primarily based on the legal definition of traditional philosophy, which includes and describes the use of traditional medicine and/or the offering of a traditional health practice.

Traditional health practice, as described in the sub-regulation of the Act, has as its goals the following four outcomes, namely to: 21

- Maintain or to restore physical or mental health, or the function of it;
- Diagnose, treat or prevent a physical or a mental illness;
- Rehabilitate a person to enable him/her to resume normal functioning within the family or community; or to
- Prepare physically or mentally, an individual for puberty, adulthood, pregnancy, childbirth and death.

The above four outcomes exclude the professional activities of a person practicing in South Africa any of the professions contemplated in the Pharmacy Act, 1974 (Act No. 53 of 1974), the Health Professions Act, 1974 (Act No. 56 of 1974), the Nursing Act, 1974 (Act No. 50 of 1974), the Allied Health Professions Act, 1982 (Act No. 63 of 1982), or the Dental Technicians Act, 1979 (Act No. 19 of 1979), and any other activity not based on traditional philosophy. 21

Pretorius33,33 describes South African traditional health practice simply as the diagnosis and treatment by traditional healers in general and diviners in particular. Pretorius33 postulates further that practices of diagnosis and treatment vary greatly and depend on the healer’s own knowledge, skills and the nature of the patient’s illness. Satisfactory healing involves the recovery from bodily—mental symptoms, and the social and psychological re-integration of patients into their communities.

Other researchers offer variations on the official legal description of diagnosis and the followed-up treatment with traditional preparations.6,11 South African traditional healers see illness as misfortune, a man-made phenomenon through bewitching, evil-doing by another or punishment by an ancestral spirit for bad and sinful behaviour. Opposite hereto, are good health and good fortune seen as rewards for good behaviour. In the traditional healthcare practice, there is no insight or concept of the modern approach of the germ-diagnosis and treatment model. It is not a case of what is causing an illness, but who is causing it. The supernatural therefore drives diagnosis and treatment.6,11

The misleading prefix “traditional” as used in the legal definition traditional health practice

The prefix traditional is a prominent legal inscription in the various sections of the Traditional Health Practitioners Act No 22 (2007), seemingly with an aim. It is constantly cited in the first part of the Act, successfully creating the impression that there is a legal separation of the traditional health practice of the South African traditional healer from the modern health practice of the medical doctor (consequently safeguarding the medical doctor from
competition by the traditional healer). This tentative dual competence of two types of healers, as created by the unclear definitions in the Traditional Health Practitioners Act No 22 (2007), clearly leaves the door open for two legal interpretations regarding the diagnosis and treatment rights and the scope of practice and services of the traditional healer. This situation is already leading to misinterpretation by the traditional healers and the various official agencies promoting traditional healing and profiling the scope of practice of the traditional healer. These legal contradictions and shortcomings pervade all the sections of the Act. It becomes more prominent later on with the omission of the prefix traditional from various legal definitions. This is undoubtedly a masked intention to open the door to the formal healthcare services and to establish a practitioner-brotherhood with the statutorily registered healthcare practitioners, specifically the medical practitioner. It is nothing less than a demarcation of the old scope of practice of the traditional healer.21

Discussion

The legal definition of traditional philosophy, strongly supported by the various sub-definitions of the Traditional Health Practitioners Act No 22 (2007), is poorly formulated and lacks a scientific underpinning. The legal definition traditional philosophy should therefore be revised comprehensively or recalled, as it is based on a spiritual intention, driven by the supernatural and superstition. It does not contain any scientific medical-legal definition on how to provide a medical diagnosis and medical treatment. It does not support a descriptive scope of practice. The other legal terms also require in-depth reconsideration and phasing-out, like indigenous African techniques, indigenous African principles, indigenous African theories, indigenous African ideologies and indigenous African opinions. The above words and phrases must be thoroughly studied, defined and explained to make legal sense of the traditional healer’s present practice system, including his scope of practice.21

The use of a description such as “traditional medicines communicate from ancestors to descendants”,21,41 as part of a medico-legal document is unheard of in the modern medical sciences or in what the medical practice regards as true, normal and scientific. One could not regard this phrase as merely symbolic either. The truth is that it is the reality of the thinking and beliefs of the practitioner of traditional healing in his present scope of practice. The same thinking and belief system are applicable to his or her patients. The primary aims and intentions of Act No 22 of 2007 versus that of the Witchcraft Suppression Act No 3 (1957) confirm this legal short-sightedness and cognitive dilemma.21,41

It is unacceptable that the phrase “communicate from ancestors to descendants” could be legally inscribed and certified as “true” and “medically scientific” in a Health Act of South Africa or can be embedded in a healthcare practice.21,42-49

It is also unacceptable in these modern times that the training and practice system of a health profession can be based on “no written documentation” of their learning programmes, curricula and the medicines used.21 It is also unheard of that legal sanction is given to a health profession of which the “health knowledge and practice, together with its medicines” are free from scientific testing and approval.21 This is the legal sanctioning of an unlimited and unrestricted scope of corrupt practice. It is a recipe for a healthcare disaster.

Neither Act No 22 (2007) nor the WHO offers a satisfactory definition of traditional philosophy. This indicate that there is a shortage of knowledge and that an “African Science of Medicine” for traditional healing does not exist.6,11 The inclusion of this legal definition in Act No 22 (2007) was a desperate and improper effort to put in writing a “non-existing traditional health science” into the South African healthcare legislation.11,21,24,25

Strength and limitations

This article unmasked the false claim of a professional scope of practice for the traditional healer in South Africa. The dearth of documentation on South African traditional healing limited an in-depth analysis.

Conclusion

It is clear that a South African traditional health practice is non-existing in terms of established standards, services, ethics, training, diagnoses and treatment. This complete failure is confirmed by the absence of a written and functional practice culture and failure of the Traditional Health Practitioners Act No 22 (2007) to constitute a written guideline to activate a future traditional health practice culture for South African traditional healers. It is not possible to speak of a scope of practice for traditional healers.
The South African traditional healers’ present practices are based on pre-modern diagnoses and treatments. Their unrestricted and unregulated practice activities as part of the South African medical fraternity are based on the supernatural and on witchcraft. As such, it endangers private and public health. They are not medical practitioners and are not trained in elementary medical sciences, but they offer at times harmful healthcare services. With their current state of education and training, they do not deserve a place in the respected statutory healthcare establishment of South Africa. Mbiti's\textsuperscript{11} classification of "traditional medicine" is misleading. They solely offer spiritual care giving. What he calls a “medicine man” is therefore a spiritual healer or priest at most. It is a case of a \textit{de facto} pre-modern religious traditional healer made a modern \textit{de jure} healthcare professional.\textsuperscript{5,6,21,50}

Legally allowing traditional healers to treat a patient with cancer or AIDS with their spiritual knowledge and dangerous medical preparations, is nothing else than making manslaughter legitimate and unpunished.  

It is misleading and irresponsible to describe the present position of the \textit{traditional health practitioners} in the South African healthcare sector in the following elevated terms: \textsuperscript{19, p.60} “Their role is that of physician, psychiatrist and priest, and people visit a traditional healer for problems ranging from social dilemmas to major medical illnesses. They therefore have a role to play in building the health system in South Africa”. Their scope of practice is undefined and murky. South Africans should be safeguarded against unregulated medical practices.\textsuperscript{41}

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(CHAPTER 3)

THE EDUCATION AND TRAINING LEVELS OF THE SOUTHERN AFRICAN HEALER: A PRESENT-DAY PERSPECTIVE


[Archives Australasian Medical Journal; Vol. 9 (2016), No. 11: The education and training levels of the South African healer: A present-day perspective]
The education and training levels of the Southern African traditional healer: A present-day perspective

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ABSTRACT

Background

The traditional healer in Southern Africa received new status as a statutorily recognized health professional with the promulgation of the Traditional Health Practitioners Act No 22 (2007). Usually such recognition is only awarded after a profession’s formal education in the form of established study programmes and training and places of learning has been confirmed. Lawmakers involved in the promulgation of the Traditional Health Practitioners Act No 22 failed to confirm the existence of such an education culture and foundation. Very little can be gauged from the formal literature on the kind and the quality of the training that the traditional healers receive and their abilities to diagnose and treat without risk to the lives of patients.

The prominent question at this stage is whether traditional healers’ levels of education and training meet the minimum requirements prescribed for health professionals in the healthcare sector.
Aims
The present study aimed to determine the education and training levels of practicing South African traditional healers.

Methods
This is an exploratory and descriptive study based on the modern historical approach of investigation and literature reviewing. The emphasis is on using present-day documentation, like articles and reports, books and newspapers, as primary sources to reflect on the present status and levels of traditional healers’ education and training. The findings are offered in narrative form.

Results
No formally established education and training infrastructure has ever been developed for the South African traditional healing profession. Up to 2007, there was also no governmental support in this regard. A formal education and training system is still in its infancy. There is, however, a well-established informal training system that developed over many years.

Conclusion
The absence of an advanced and statutorily recognized education and training system can make the immediate change-over from traditional healing as an unregulated endeavour to a profession and acceptance of the traditional healer as part of the healthcare establishments, very difficult and problematic. Over against this, there is a functioning informal training system exists, confirming that minimum levels of education and training are present.

Key Words
Afterlife, ancestor, healthcare, levels education and training, mental impairment, novice

What this study adds:
1. What is known about this subject?
Very little has thus far been published on the education and training of the traditional healer.

2. What new information is offered in this study?
This study’s focus was to collect information on the education and training of traditional healers in an effort to offer a professional profile of the South African traditional healer.

3. What are the implications for research, policy, or practice?
The absence of a sound formal healthcare education and training foundation can disqualify the traditional healer as a professional health practitioner.

Background
The Southern African traditional healer’s role in healthcare has been a topic of hot debate for many years. At the centre of this debate is the traditional healers’ failure to demonstrate that they are, in terms of formal healthcare requirements and standards, able to practise as healthcare professionals within the established healthcare sector. The official entry of traditional healers to healthcare through the Traditional Health Practitioners Act (Act No 22 of 2007) does not solve the issue. In fact, the Act compounds the situation. The intent of health and government authorities to bring the traditional healer, defined as traditional health practitioner, into the established health sector without any formal education and training, training facilities or any established patient responsibility and ethic code, is a serious matter.

In view of modern healthcare standards and requirements, it seems that modern traditional healers in Southern Africa lack medical knowledge and skills. There is no formal quality control of the content, duration or level of their
education and training. They argue that they learn mostly through the supernatural. One gets training in traditional healing if you have been “called” by the ancestors and spirits, while mental impairment and disarrangement and psychosis also sometimes play a role in this calling. The period of training, the learning matter and examination of competence are undefined at present.2,3

Initially the reaction of the established South African health sector to the traditional healer as a new partner after the promulgation of the Traditional Health Practitioners Act No 22 in 2007 was very nonchalant. This may be due to the Traditional Health Practitioners Council (THPC) and the traditional healers’ failure to get Act No 22 enacted and to steer it into implementation. Since the end of 2015, however, with governmental efforts and support to get the Act running, the future role of the traditional healer in the country’s healthcare has become prominent.1

The current lack of formal training and education for the traditional healers is a direct result of their exclusion, over many years, from a strong education and development system aimed at making practitioners effective in healthcare delivery. This meant that they missed out on support for their early training and development. The situation is different for other health profession. Such empowerment, development and support, would have offered the South African traditional healers a start with an excellent system of education and training. This, in turn, would have resulted in an excellent system of diagnosis and treatment, ending in the third and last instance with an excellent scope of practice. Such a process could have developed them into respected and trusted members of the South African healthcare fraternity years ago.2,3

The traditional healers now stand before an immense challenge. The public and the formal healthcare sector want them to create a formal training and education system as fast as possible. This is something that the established healthcare professions were fortunate to create over many years, mostly with government support. The question is: are the present South African traditional healers really too untrained and uneducated to be proper healers?2,3

The aim of this study is to evaluate the levels of education and training of the Southern African traditional healer.

Method

This research was done by means of a literature review. The method builds a viewpoint based on evidence as developed in the literature. This method is used in modern historical research where there is a lack of information. The databases used were EBSCOHost, Sabinet online and various contemporary sources, like articles for the period 1993 to 2016, books from 1990 to 2013, newspapers and reports for the period 1984 to 2014 and governmental documents covering the period 2007 to 2015. These sources were examined to reflect on the levels of training and education of the traditional healers.4,5 The research information is presented in narrative form.

Results

The absence of formal registered programmes for traditional healing as part of the National Qualifications Framework (NQF) and the absence of registrations of qualifications with the South African Qualification Authorities (SAQA), do not mean there are no existing alternative forms of training for traditional healers in South Africa. To the contrary, it is clear from a literature overview that there is an informal traditional health culture of practice and training that is unique to South Africa. In this regard, it is important that South African traditional healing is not confused or compared with the training and educational systems, cultures and histories of traditional Chinese medicine, homeopathy, naturopathy or Ayurveda that are also practised in South Africa. Traditional leaders clearly broke away from these disciplines in the 1970s with the exclusive statutory recognition of the allied health professions in South Africa. This recognition left traditional leaders out.

A literature review shows that there are three avenues to explore, evaluate and describe the levels of education and training of the present-day traditional healers in South Africa, namely:

1) The Traditional Health Practitioners Act No 22 (2007).

2) Literature and publications of traditional healers.

3) Research on traditional healing.

These avenues are explored in the Discussion.
Discussion

Act No 22’s description of the education and training levels of traditional health practitioners

The Traditional Health Practitioners Act No 22 puts certain definitions in place about the education and training levels of the incoming traditional health practitioner. It basically describes how the training of the traditional healer should be directed in the future. The Traditional Health Practitioners Act (No 22, 2007) and the Traditional Health Practitioners Regulations of 2015 (No 1052) do not describe the contents of traditional healing training, the examination of the learner-healer at the end of his training or by whom this should be done.1,6

Regulations No 1052 (2015) prescribes the educational level needed to enrol for training, namely an ABET Level 1- qualification (School Grade 1-3) or an equivalent. Also, Regulations No 1052 (2015) prescribes a minimum duration of study for the various subtypes of healers: a 12-month internship for students in divination, herbalist and birth attendants respectively and five years for the traditional surgeon. The traditional Health Practitioners Act No 22 (2007) does not describe the structures involved or the training itself, nor does it offer any detailed description of institutions to train the new healers.1,6

Publications and declarations by traditional healing organizations on the current education and training levels of the traditional healer

Traditional healer organizations had taken it on themselves to educate and train individuals and groups as traditional healers in an effort to make up for having been side-lined for decades by the established healthcare sector and the formal training sectors. The literature on training produced by these organizations makes clear that to be registered with one of these many traditional healing organizations, the healer, whether herbalist, sangoma or inyanga, has to have had five years of training as an apprentice healer. The applicant furthermore has to pass an oral and written examination to be awarded the certificate of practice and allowed to take the Healer’s Oath of Ethics. Practicing unethically, dabbling in politics and having a bad reputation in the area can cause his expulsion from the organization. These organizations also require that all herbal shops must obtain a municipal license and be registered with the necessary authorities to ensure standards and ethics.7,8

Literature also states that the traditional healers have knowledge of traditions and of healing by means of different traditional health practices. This knowledge is transferred to student healers through their training programmes. Some of their short courses were accredited by the Health and Welfare SETA. It seems that they also offer certified training on 10 different traditional health specialist practices.7,8

In an effort to overcome their exclusion from the formal systems and to guarantee the standard of their education and training, the various traditional healers’ organizations also started early on to issue their own certificates of registration and of competence to their students after graduation. With these warrantees, they assure every patient that a trained practitioner has completed training of a good standard, has passed assessment successfully and is capable of giving services to the patient in an ethical, efficient, safe and hygienic way.9

Traditional organizations also put rules in place. To qualify and to register with them as a traditional healer, the candidate has to serve an apprenticeship of between one and five years and the person must be well known within the community served and among the other traditional healers. Some of these local traditional healers’ organizations have training and working agreements with traditional healers’ organizations of countries in Africa, Asia, Latin America, Europe, and Australia and these organizations recognize their qualifications. Locally many of the traditional healers’ organizations also recognize each other’s qualifications.10

From the literature it is also clear that the student healer receives in-house-training under the guidance of another traditional healer, known as a master or tutor healer. This system is more or less in line with the old guild system in Britain where the apprentice or novice trained or articled under a master or tutor for a certain period.2,3,11,12

Researchers’ and writers’ reflections on the educational levels of the present-day traditional healer

The literature offers various thorough descriptions regarding the education and training of the traditional healer. These studies confirm that the contemporary traditional healer of South Africa is someone who has been through a period of initiation under another traditional healer and who has undergone rigorous and complex training and has completed external courses.12-23
Gumedede\textsuperscript{24} confirms the apprenticeship training, but adds that the levels of learning are very elementary: the novice has to do physical and mental exercises. He writes:\textsuperscript{24} “Every morning she stirs and churns her clay pot of ubulawu, drinks it, and then washes her face. The froth enables her to see clearly when she divines. The novice spends a lot of time in the veldt studying nature. She follows many paths being led by the spirits. She studies herbs as well under the guidance of her tutor. Dancing the diviner’s dance is one of the most important exercises. This is her \textit{tedium}” (p. 75).

Gumedede\textsuperscript{24} further describes the education and training of the novice by mentioning that her tutor gives her divining exercises where she has to find hidden objects. She is given many mental exercises, learns meditation, goes into séances, travels to far-away lands in dreams and enters into commission with her ancestral spirits. When the tutor is satisfied with the changes, the novice goes through the Ukunqwambisa ceremony for graduation.

Various other writers emphasize that learning to be a traditional healer is to be trained formally under another sangoma for anywhere from a number of months to many years and that the training content involve the learning of humility before the ancestors, purification through steaming, washing in the blood of sacrificed animals and the use of muti (medicines) with spiritual significance. During the training period, the learner is forbidden to see his or her family, must abstain from sexual contact and often lives under harsh and strict conditions. This intense experience of training is part of the cleansing process to prepare the healers for a life of dedication to healing. Their formal education and learning also includes the analysis of dreams.\textsuperscript{21}

Truter\textsuperscript{25}, in reporting on the formal education and training of the different categories of healers, mentions that the training of a \textit{sangoma} requires training under a qualified diviner for several months. During this learning period, the mentee learns to throw the bones and experiences trance-like states where communication with the spirits takes place. On completion of training, he or she undergoes the process of ancestral spirit possession when he or she is called by ancestors to become a healer. There is no fixed period of training; it may take anything from six months to ten years. An inyanga intern spends a few years as apprentice, the birth attendant apprenticeship entails 15 to 20 years of training, while the student umthandazi’s period of training is not described. Qualifying depends on two factors: first, the teaching sangoma only allows a pupil to qualify once a final fee has been paid, and second, the sangoma retains territorial exclusivity, where the pupil pays allegiance to the teacher.\textsuperscript{25}

Mbiri\textsuperscript{26} writes about the education and training of the learner medicine man. Such a person associates with a skilled medicine man for training. This can last up to ten years or even longer. Learning consists of learning the names and nature of herbs, trees, roots, seeds, bones, birds and animal droppings (excreta) and many other things that are used for making medicines. It also consists of learning how to diagnose diseases and troubles of every sort, how to handle the patients, how and what to prescribe as the cure, and in general how to perform one’s duty as a medicine man. All this may be called the “Science of Medicine”, according to Mbiri.\textsuperscript{26}

The healers of the Zulu people, the \textit{inyanga} who specialize in herbal medicine and potions, and the \textit{isangoma} who use divination, mediumship and psychic healing, acquire their knowledge through “long apprenticeships” under a master healer.\textsuperscript{27}

In Lesotho most traditional healers is said to have received the calling from their ancestors while asleep (34 per cent). The ancestors reveal to the novice who will train them further on traditional healing. A further 34 per cent acquire their knowledge from their elders, usually as employees of traditional healers. They gain knowledge when they are sent out to fetch herbs or medicinal plants and animals. There is another category (28 per cent) that never goes through any form of training, but claims to have been shown various medicinal plants and animals by their ancestors while asleep.\textsuperscript{28}

A study involving Bapedi traditional healers (n=34) in Limpopo reflects that most of the males (48 per cent) acquired their healing knowledge from fellow traditional healers, 38 per cent learned it from their parents and 14 per cent from grandparents. Among the females, 62 per cent received training from their parents, 38 per cent from fellow traditional healers and 8 per cent from grandparents.\textsuperscript{29}

\textbf{Southern African traditional healers’ formal scholastic and tertiary education}

Another way to gain insight into the healer’s level of educational and training is to evaluate the person’s formal scholastic and tertiary education from case studies.
In an effort to examine traditional healers’ formal scholastic and tertiary status in terms of case studies, various South African articles, books and other forms of publications on traditional healers were consulted. Four studies were identified.29-32

A KwaZulu-Natal study with Zulu traditional healers reports that all the healers had attended school in some form, as many as 20 per cent had obtained tertiary qualifications.31 A study with Xhosa traditional healers reflects that 35 per cent attended primary school, 50 per cent secondary school and 3 per cent tertiary institutions.32 The third study, involving 34 Bapedi healers from Limpopo, reports that 76 per cent of the males and 46 per cent of the females had no formal education (average=61 per cent), 19 per cent males and 31 per cent females attended primary school (average=25 per cent) and 5 per cent males and 23 per cent females secondary school (average=14 per cent).29 The three studies show that very few traditional healers have had tertiary education.

A comprehensive investigation in Lesotho28 used a sample of 91 traditional healers [and 108 users or beneficiaries of traditional medicine]. This study by the African Technology Policy Studies (ATPS)28 found that out of these so-called “traditional doctors”, 56 per cent had schooling at a primary level and that 23 per cent had not been to a formal school. Some 14.3 per cent had only attended traditional schools, meaning that they possess only indigenous knowledge, gained from initiation school and their elders and while tending livestock. Of the traditional healers, only 4.4 per cent attended high school (grade 8 to grade 12), while as little as 2.2 per cent obtained some form of tertiary education (NQF 5-level and higher, but not necessarily a tertiary qualification).28-33

Strength and limitations

This study lays bare the low levels in education and training among present-day South African traditional healers. The absence of written curricula, study-guides, proper qualifications and training institutions to visit and to evaluate, limits the depth of the evaluation.

Conclusion

Although there seems to be no formal programmes, qualifications and learning institutions for the traditional healer, there undoubtedly is an age-old, but still well- functioning informal traditional healing educational and training system in place. Literature confirms the existence of specific levels of education and training, strong enough and independent enough to support the viability and sustainability of the South African traditional healer.

Despite its informal nature and lower scholastic standard compared to the training of the regulated healthcare professions, the traditional healers’ education and training system seems to be strong enough to overcome resistance to statutory recognition and to help the group to transition to a health profession.

The Traditional Health Practitioners Act No 22 can be enacted fully and quickly if the traditional healer’s unique and informal traditional healthcare culture of education and training is recognized by the South African education and learning authorities. This knowledge must be de-stigmatized and integrated into the Traditional Health Practitioners Act No 22’s various descriptions and definitions. A culture of customary training can become internalized in the minds of traditional healers, the public and the established healthcare sector if the unwritten education and training system of the traditional healer is comprehensively described. This can serve as a guideline to steer the intentions of the Traditional Health Practitioners Act No 22 on the future education and training of traditional healers.

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THE PRESENT-DAY DIAGNOSIS AND TREATMENT MODEL OF THE SOUTHERN AFRICAN TRADITIONAL HEALER

The present-day diagnosis and treatment model of the South African traditional healer

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RESEARCH

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ABSTRACT

Background
At present, no formal guides or curricula exist to direct and instruct diagnosis and treatment in the practice of the traditional healer. To gain knowledge of how the traditional healer makes diagnoses and offers treatment, the researcher has to rely on the reflections in the literature as well as writings and communications offered by a few authors and the traditional healer organizations. These materials are sometimes insufficient and even misleading and cannot serve as trustworthy information in isolation.

Aims
The present study is aimed at determining and describing the present diagnosis and treatment model of the traditional healer.

Methods
This is an exploratory and descriptive study in line with the modern-day historical approach of investigation and reviewing research. The emphasis is on the study of present-day documentation, like articles, books and newspapers as primary resources to reflect on the development and promulgation of the Traditional Health Practitioners Act No 22 (2007). By implementing this approach, new information can be uncovered on the present-day diagnosis and treatment model of the traditional healer. The findings are offered in narrative format.
Results

The regulations and definitions of the Traditional Health Practitioners Act (Act No 22, 2007) is not effective in evaluating the procedure of diagnosis and treatment of the present day traditional healer, as this act, being promulgated in 2007, is applicable to diagnosis practices and training processes still to be developed.

Conclusion

A traditional healthcare model based on scientific research to guide and teach the student of traditional healing and about diagnosis and treatment is non-existent in South Africa. Traditional leaders acquire their current knowledge and understanding of the diagnosis and treatment through various doubtful ways of learning, mostly verbally and in practice from unqualified traditional healing masters or tutors. This means that the pre-modern traditional health know-hows, styles and approaches which are being offered, differ immensely in standards from tutor to tutor.

Key Words

Ancestral spirit, religious acts, traditional philosophy, traditional medicine, spiritual, curative medicines, muti

What this study adds:

1. What is known about this subject?

There is a dire need for a formal description of the present-day diagnosis and treatment model of the South African traditional healer as no such documentation could be found.

2. What new information is offered in this study?

This research reflects a new view on the perception of concepts, diagnosis and treatment concerning traditional healing in South Africa. It confirms the absence of a formal academic and professional curricula and training in traditional medical science, pre-requirements necessary to make a scientifically medical diagnosis and to offer a responsible medical treatment.

3. What are the implications for research, policy, or practice?

Act No 22 (2007) is an improper legislation basically promulgated to establish a pre-modern care-giver, without any accepted medical know-how, as a modern-day health practitioner.

Background

At present, there is no formal curriculum on traditional health training that direct and instruct the traditional healer to make his diagnosis or to perform his treatment. The only official guideline on these matters is linked to the definitions traditional philosophy and traditional medicine of the Traditional Health Practitioners Act No 22 (2007). These directives are aimed at implementation in future as the traditional health practitioner is a figure still to be officially installed and regulated when Act No 22 is fully activated. At present, the only knowledge of the present-day diagnosis and treatment methods and styles of the traditional healer is the definitions, descriptions, declarations, etc., offered by writers, researchers as well as activists and propagandists. This information can be instrumental to reveal the real practice activities of the traditional health practitioner.1-9

The aim of this study is to determine and describe the model of present-day diagnosis and treatment by the South African traditional healer.

Method

The research was done using the method of literature review. This method aims at reaching conclusions derived from evidence as the research proceeds. This approach is used in modern historical research where there is a lack of an established body of knowledge. The databases used are EBSCOHost, Sabinet online as well as various contemporary sources, like newspapers from 2014, articles from 1979 to 2014, books referring to the period 1958 to 2013 and governmental documents covering the period 2003 to 2007. These documents were informative about the development and the promulgation of the Traditional Health Practitioners Act No 22 (2007) and putting the thoughts and opinions on the present-day diagnosis and treatment model of the South African traditional healer in perspective.10,11 The findings are offered in narrative format.
Results

Diagnostic approaches and styles

Various diagnostic and treatment approaches and practice styles, unique to the traditional healer, are captured in South African literature. These descriptions, although from secondary resources, offer insight into the diagnosis and treatment used in traditional healing and compensate for the lack of formal, written curricula and primary resources on traditional healing.

The traditional healer as diagnostician

Literature shows that the central role of the traditional healer as diagnostician is to identify through his so-called supernatural powers the reason for unnatural illness and unnatural occurrence to individuals or communities. He must ascertain who (and not what) causes misfortune or illness that can only be brought on by ancestral spirits or witches. This concept of diagnosis is clearly reflected in the meaning and intention of the definition traditional philosophy in the Traditional Health Practitioners Act No 22 on which the South African traditional healing is based.12-15

To be able to perform a diagnosis and offer treatment in line with this traditional philosophy, it is assumed that the traditional healer receives certain supernatural powers to benefit the community through his so-called “heredity- selection”. Accordingly, it is believed, that the traditional healer is a sacred servant of the community and in terms of the esoteric knowledge he possesses, he alone can communicate with the spirits on the wills and wishes of the living. Making his diagnosis he relies on magical powers that involve rituals and ceremonies that include the use of substances (muti) made from herbs and animals (and sometimes human parts), verbal spells that are believed to invoke divine intervention as well as the use of esoteric methods and interpretations.12-14

This explanation reveals a misconception among people practising and consulting traditional healing concerning the meaning of the notions diagnosis and treatment as understood by modern medicine. This misconception is clearly illustrated by the definition of the “African Science of Medicine” which falsely portrays the pre-modern and supernatural training of the traditional healer as to be based on modern medical principles. The same misconception is reflected by their definition and understanding of the concept “protective medicine” in which they exclusively use muti for protection against misfortune and illness, while modern medicine regards “protective medicine” in the sense of inoculation using safe and effectively tested medicine to prevent an illness like poliomyelitis.14

A further confirmation of this misconception of modern medicine (and thus the medical diagnosis and treatment procedures that go with it), is the remark by Mbiti14 that “medicine in the African society has a wider meaning as in modern society”. It has also been verified that the medical concoctions and muti of the traditional healer do not have the healing qualities of the medicines certified by the Medical Control Council (MCC) medicines. These traditional “medicines” do not intend to heal bio-medically but is only an expansion of the supernatural diagnosis and treatment of the traditional healer.12-14

From the ranks of the traditional healers also comes the acknowledgement that they do not have any modern medical diagnosis and treatment at their disposal. For example, being consulted about a new illness a healer might react as follows:16 “On occasion a healer will be confronted with a new and strange disease. In these situations the herbalist will seek assistance from the spiritual world” (par. Healers Herbalists).

The education and training model of traditional healing

It is clear that education and training of the South African traditional healer occurs in an informal environment of no formal education, controlled standards, learning programmes, established institutions or hospitals. There is no indication of any academic culture equivalent to that of a medical doctor. The traditional healer’s skills, competence and abilities are not in any way regarded as being the same as that of a modern health practitioner. No evidence of a medical culture being embedded in an earlier established medical foundation that still exists today was found. Furthermore, no evidence of a formal traditional healing fraternity acting as the guardian of traditional healing programmes, the teaching of practice and skills that include diagnosis and treatment, was discovered.17-19
The present-day traditional healer is evidently a kind of spiritual healer, totally lacking an acceptable medical identity. The nearest association to the traditional healer with the medicine model is the psychologist and psychiatrist, specifically regarding some practice similarities. But, due to inadequate training, the traditional healer is not able to make a medical, psychological or psychiatric diagnosis in terms of the codes of the International Statistical Classification of Diseases and Related Health Problems (ICD-10 code), for him to be at the same level with the psychologist or psychiatrist. In addition, a similar problem emerges for his medical concoctions to obtain rating from the MCC or the Self-medication Manufacturers of South Africa (SMASA). 20–23

The present-day diagnosis profile of the traditional healer

In view of the mentioned findings regarding the traditional healer as a health practitioner without medical certification or licensing and his lack of formal medical or health education, the kind and level of diagnosis and treatment offered by him appear suspicious.

Literature offers a broad overview by researchers and writers on how traditional healers are making their diagnoses and treatments. Some approaches present similarities regarding activities, point of focus, creed, view on present and future life, as well as utilizing certain diagnostic tools and medicinal concoctions. However, certain approaches differ completely and are even in conflict with others.

The approaches towards diagnosis are mainly the following:

- The traditional healer generally obtains guidance from an ancestral spirit. These instructions usually come through dreams or when praying. The healer thus receives direction when, where and with which particular plants to make muti for a specific patient and where these plants are located.9,24

- Some healers employ charms, incantations and casting of spells to make a diagnosis. The dualistic understanding by traditional African medicine of themes such as body—and soul, matter and spirit, and their interactions, is perceived as magic (witchcraft). It is also believed that healers are able to implant from a distance a foreign object into a person’s body to inflict sickness. To remove this malignant object, the intervention of a second healer is required. He removes the object from the affected person by making an incision. Another form of magic (witchcraft) is the so-called sympathetic magic in which a model is made of the victim. Actions performed on the model are transferred to the victim in a way similar to the familiar actions on a voodoo doll. Where spirits of deceased relatives trouble the living and cause illnesses, the healer applies remedies like propitiatory sacrifice to put the spirits to rest.8

- The act of diagnosis and healing in an African context is considered to be a religious act. The healing process attempts to appeal to God because only God can inflict sickness or provide cures. This intervention is performed through the medium of spirits.1,8

- Health and illness are perceived in the same light. Traditional healers are consulted for a wide range of reasons such as physical, psychological, spiritual, moral and social problems. Healers are also consulted to obtain ministrations to prevent illness and misfortune.25

- While making his diagnosis, the traditional healer always takes into account the connection between the client/patient and his ancestral spirits. The living and the dead have a duty toward each other. Therefore good health or illness is regarded as a net result of a delicate and intricate balance between a man’s family and his relationship with the ancestral spirits. Good health and good fortune are rich rewards for good behaviour and constant sacrifice to the ancestral spirits while illness is a punishment for sins of commission and omission.12

- It is believed that the healer receives instructions and advice from ancestors in the spiritual world to diagnose and heal illnesses, social disharmony and spiritual difficulties. In order to make a diagnosis, healers believe that they are able to access advice and guidance from the ancestors on behalf of their clients (patients). This is achieved through possession by an ancestor, channelling, throwing bones, or by interpreting dreams. It is believed that the spirits have the power to cause affliction they also connect the healer to the acting spirits. Helping as well as harming spirits are believed to use the human body as a battleground for their own conflicts. With his understanding of traditional philosophy on diagnosis, the
A traditional healer is able to create harmony between the spirits which results in the alleviation of the patient's suffering.\(^9\)

- Diagnosis is reached through spiritual means, while the resulting treatment consists of herbal remedies which have supposed healing, symbolic and spiritual abilities. In traditional African medicine, the belief is that nobody becomes sick without sufficient reasons and that illness is derived from spiritual or social imbalances within the person. Natural causes (medical or physical) are regarded as the manipulations of spirits or the gods. Sickness is sometimes said to be attributed to guilt in the person, family or village for a sin or moral infringement. The illness manifested stems from the displeasure of the gods due to an infraction of universal moral law. Given the type of imbalance, appropriate healing needs the making of a “proper” diagnosis.\(^8\)

Pretorius\(^5\) refers to traditional diagnosis as “a system that is both an art and a method of seeking to discover the origins of the disease and determining what it is” (p. 4). The diagnostic process not only seeks answers to the question of how the disease started (immediate causes), but also who or what caused the disease (efficient cause), and why it has affected this particular person at this point in time (ultimate cause). Diagnosis comprises a combination of information, namely observation, patient self-diagnosis and divination. Observation involves noting physical symptoms, while patient self-diagnosis entails patients reporting their symptoms. If deemed necessary, the impressions of other family members regarding the patient’s illness may also be obtained. Three methods of divination are described and include the casting of divination objects, mediumistic ability (clairvoyance/telepathy) or dreams and visions.

Mbiti\(^14\) and Essien\(^26\) also emphasize that the major illnesses and life troubles in the African society are usually diagnosed and explained as religious experiences and clearly not as biological/medical conditions as in modern medicine. Essien\(^26\) reports specifically that the traditional healer’s diagnosis signifies aiding human spiritual health and adjustment through superstition, magic and religious actions and not by real medicine.

Also in terms of the concept of diagnosis, it is clear that Gumede\(^12\) sees traditional diagnosis as an essential part of religion, with the central figure accomplishing this diagnosis being the traditional healer as a priest, not as a medical doctor.

- It is clear that a medical diagnosis, developed by the already regulated health professions such as nursing, the allied and allopathic professions, is completely absent in traditional healing. The traditional healer’s diagnosis (traditional diagnosis) is founded in faith in the supernatural.

**The present-day treatments profile of the traditional healer**

Treatment is only administered after making a diagnosis and deciding on a treatment plan. Several authors have placed descriptions of a wide range of treatments of the traditional healer on record.

About the treatments offered by the traditional healers, Pretorius\(^5\, pp.4-7\) writes:

- Traditional medical practitioners treat all age groups and all kinds of problems, using and administering medicines that are readily available and affordable. Their treatment is comprehensive and has curative, protective and preventive elements. Treatment can be either natural or ritual, or both, depending on the cause of the disease. Treatment includes among others, ritual sacrifice to appease the ancestors; ritual and magical strengthening of people and possessions; steaming; purification (e.g., ritual washing or the use of emetics and purgatives); sniffing of substances; cuts cutting (African mode of injection); wearing charms; and piercing (African acupuncture).

- Traditional healers also deal with traditional ailments. These culture-bound syndromes usually do not respond to western medicine and must be treated by traditional healers (Zulu: ukufa kwabantu). There are five such culture-bound syndromes viz being possessed by (evil) spirits, sorcery, ancestral wrath (esinyanya), neglect of cultural rites or practices (amaseko), and defilement.

Regarding the scope of traditional healer’s treatment, Pretorius\(^5\) states that the traditional healer deals with the following categories of conditions:

- Conditions of the respiratory system: e.g., colds and flu; hay fever; pneumonia; asthma; bronchitis; emphysema; tuberculosis.
• Conditions of the gastro-intestinal system: e.g., diarrhea; dysentery; constipation; heartburn; indigestion; ulcers; hemorrhoids; worms.

• Conditions of the cardiovascular system: e.g., angina; high blood pressure; palpitations.

• Conditions of the central nervous system: e.g., headache; migraine; stroke (traditional treatment is given after discharge from hospital).

• Conditions of the skin and hair: e.g., acne; eczema; boils; insect bites and stings; ringworm; scabies.

• Conditions of the blood: e.g., anemia; blood cleansing.

• Conditions of the urino-genital system: e.g., sexually transmitted diseases; cystitis; menstrual pain; vaginitis.

• Conditions of the eyes: e.g., “pin eye”.

• Conditions of the musculoskeletal system: e.g., arthritis; backache; muscular pain; gout; sprains and strains; rheumatism.

• Other conditions such as cancer; HIV/AIDS (some cultural beliefs maintain that there is no such thing as HIV/AIDS or it is sometimes confused with lugola - a culture-bound syndrome that mimics HIV/AIDS); fever; pain; alcoholism.

Another author also indicates that traditional healers use a wide variety of treatments – from "magic" to biomedical methods such as fasting and dieting, herbal therapies, bathing, massage, and surgical procedures. Migraines, coughs, abscesses, and pleurisy are healed by using the method of "bloodletting" followed by an application of herbal ointment with follow-up herbal drugs. Sometimes animals are also used to transfer the illness to. Some healers rub heated herbal ointment across the patient’s eyelids to treat headaches, while malaria is treated by both drinking and inhaling the steam of a herbal mixture. Fevers are often treated using a steam bath. Vomiting is induced and emetics are used to treat diseases, e.g., raw beef is soaked in the drink of an alcoholic to induce nausea and vomiting as a cure for alcoholism. The fat of a boa constrictor is used to cure gout and rheumatism. It is also believed to relieve chest pain when rubbed into the skin.

Other forms of treatment are purification rituals. The casting of bones to access the advice of ancestors is an alternative practice to ritual of exorcism of spirits. In a typical session, the sangoma should determine what the affliction is or what the reason for the patient’s visit might be. The patient or diviner throws bones on the floor. This collection of objects may include animal vertebrae, dominoes, dice, coins, shells and stones, each with a specific significance to human life, e.g. a hyena bone signifies a thief and will provide information about stolen objects. The sangoma or the patient throws the bones but it is believed that the ancestors determine the pattern they form when they land. The sangoma then interprets this metaphor in relation to the patient’s treatment: what is required from the patient by the ancestors, and how the disharmony is going to be resolved. Similarly, sangomas also interpret metaphors present in dreams, either their own or those of their patients.

The spiritually curative medicines prescribed in traditional treatments are called muti. Traditional African medicine makes extensive use of botanical products, but may also include other formulations which are zoological or mineral in composition. Different types of muti are prepared from approximately 3,000 out of 30,000 possible species of higher plants of Southern Africa.

Depending on the affliction, a number of purification practices can be administered. These practices include bathing in herbal mixtures; self-induced vomiting to cleanse and tone the system; inhaling the steam of medicinal herbs; the use of snuff to induce sneezing to expulse diseases; enema infusions and decoctions and the application of extracts to small cuts.

In some cases, treatment with the traditional healers’ muti is obviously meant to be ill-disposed, as Hofstatter reveals:

• “Gris-gris consist of pouches and horns – and sometimes hooves and vials – containing special powders. They are strung along belts, hung around the fighter’s neck or slung over his shoulder. The garland carries a padlock that must be unlocked when not in battle. ‘Otherwise the gris-gris causes discord. You will start fights with your family. Your car won’t be able to start’.

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The hoof is a particularly dangerous weapon. ‘During a fight, it can turn you into a snake or the wind so your enemy can’t see you. It’s deadly.’ Gris-gris also salves your conscience. ‘When you kill someone, the ghost of the person will not disturb you – the gris-gris will chase it all away’

Truter identifies three categories of traditional medicine in treatment:

- Preventive and prophylactic medication: Most of the work of traditional healers involves protecting patients from possible afflictions. This can be achieved in various ways, for example by performing ceremonial acts; using medicine against disequilibrium; wearing totemic objects. For fortification these objects are scattered around and about the kraal to ward off lightning or evil pranks that a witch of some kind endeavours to bring about.

- Treatment for ailments: These are prepared in different forms such as cold and hot infusions, decoctions, powders, poultices and lotions, and a variety of earthy ointments that comprise animal fat, clay and sometimes ash. These formulations are made into different medicine mixtures. These recipes are usually a secret and form part of the knowledge that the healer passes on to his apprentice.

- Medications used to destroy the power in others: These medications target specific individuals. A concoction may be placed in the enemy’s path and it is then believed that when the enemy passes by, he will contract a fatal disease. Scarification, bloodletting and cupping are the commonest surgical procedures performed by African traditional healers and are occasionally performed in full view of onlookers. The letting of blood is sometimes used as a way of casting out the illness. If the cause of the sickness is perceived to be witchcraft, a number of rituals may be performed in order to cast off the spell. These may include the induction of vomiting, enemas, bloodletting, whistling or elaborate rituals such as animal sacrifices. Rituals play an important role. Many Africans believe that if the ancestors withdraw their protection and gift of good fortune, 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 violation of customs and traditions or non-observance of certain taboos. The rituals performed in traditional medicine aim to restore balance and harmony in terms of the beliefs and values of its culture. These rituals reduce patients’ anxiety and serve to relieve feelings of guilt. A large part of the African traditional healer’s practice is also devoted to counselling individuals.

To Mbiti and Essien, the treatment with muti is essentially a religious component of traditional medicine. Treatment rituals are necessary to confirm that life’s troubles in the form of magic, sorcery, witchcraft, broken taboos and the work of spirits are laid to rest. Essien emphasizes that treatment with “medicine” in terms of the traditional healing involves amulets, charms, herbs, sorcery, etc. Such treatment is not meant to heal an illness biomedically or physically, but to block out supernatural misfortune and illnesses caused by spirits or witches. These authors do not refer to any modern, scientific or bio-medical treatment at all.

The Traditional Health Practitioners Act No 22 also fails to rectify the future description of treatment by the traditional health practitioner. The scientific intention of its definition traditional medicine, meaning an object or substance used in traditional health practice for the diagnosis, treatment or prevention of a physical or mental illness, or any curative or therapeutic purpose, including the maintenance or restoration of physical or mental health or well-being in human beings, but does not include a dependence-producing or dangerous substance or drug, is gobbled up by the Act’s pre-modern pivot definition of traditional philosophy, connecting directly to the ancestors, spirits and supernatural inclinations.

The treatment-model of the traditional healer, based on his failed diagnosis model, is yet again exclusively focused on the supernatural. The adjusted term should more accurately be traditional supernatural treatment. The sound medical treatment model of the medical doctor clearly does not exist in traditional healing.

Discussion

Diagnosis and treatment present in traditional health allegedly regarded to be unique to the traditional healer and which had justified his right to be a healthcare professional, allowed to work in South Africa’s health establishment and services in terms of the Traditional Health Practitioners Act No 22, are certainly not based on any medical or scientific principles, knowledge or certification. A close examination of literature mentioned, revealed that there is no uniform traditional diagnosis and treatment model. Specific dissimilarities exist amongst
traditional healers in their approach to diagnosis and treatment. Furthermore, the traditional healer’s diagnosis and treatment are founded in the supernatural, stripped of any bio-medical standing. Its written diagnosis and treatment manifest is carte blanche.

Research also indicates a lack of understanding of the concepts of diagnosis and treatment, not only within traditional healing realm, but also among the composers of the Traditional Health Practitioners Act No 22 and certain portions of the South African community.

Any form of training, based on formal academic or professional health programs and standards and attended by the learner-healer, is not found. In addition, there is no evidence that the mentor (tutor) is formally trained in health sciences or practice. Traditional diagnosis and traditional treatment are exclusively directed by the supernatural and magic. Thus, it is possible that the diagnosis and treatment of the traditional healer incline towards witchcraft, even evil-doing, including murder.

**Strengths and limitations**

The contribution of the study is the realization that no medical diagnosis and treatment model for the South African traditional healer could be detected. The traditional healer is completely deprived of his status as a medical health practitioner. The fixed and stereotyped idea of the professed true qualities of the South African traditional healer as a medical entity, supported by politicians, activists and propagandists, will regretfully limit the impact of the study to rectify the confusion and misinterpretation created by the Traditional Health Practitioners Act No 22 (2007).

**Conclusion**

A scientific traditional healthcare model to guide and teach the student of traditional medicine the skills of diagnosis and treatment of his clients, is absent in South Africa. At the moment, knowledge and understanding of diagnosis and treatment of traditional healing are obtained through various informal ways of learning, mostly verbally and practically, from so called “traditional healing masters or tutors”. In reality, this means that the present-day traditional health advices, styles and approaches being offered, differ immensely in standards from tutor to tutor.

We believe that the lack of an established medical diagnosis and treatment learning model and a code of ethics regarding practice responsibility and client health safety for the South African traditional healers, are matters that need to be addressed soon.

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(CHAPTER 3)

THE INSUFFICIENT FORMULATION AND VAGUENESS OF THE DEFINITION “TRADITIONAL HEALTH PRACTITIONER” AS INCLUDED IN THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) OF SOUTH AFRICA


[Archives Australasian Medical Journal; Vol. 9 (2016), No. 12: The insufficient formulation and vagueness of the definition “Traditional Health Practitioner” as included in the Traditional Health Practitioners Act (Act No 22, 2007) of South Africa]
The insufficient formulation and vagueness of the definition ‘Traditional Health Practitioner’ as included in the Traditional Health Practitioners Act (Act No 22, 2007) of South Africa

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**RESEARCH**

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**ABSTRACT**

**Background**

The main focus of the Traditional Health Practitioners Act No 22 (2007) is the regulation of traditional healing in South Africa. The role player who has to deliver this traditional health service to the public is the statutorily recognized traditional health practitioner. However, thus far the precise health practice offered, training and the practitioner’s role as a healer in the society, have not been clearly defined. The various definitions and descriptions in the literature of the identity of the traditional healer are contradictory, making the formulation of a single definition and meaning impossible.

**Aims**

The study aimed to determine a definition for traditional health practitioner.

**Methods**

This is an exploratory and descriptive study in line with the modern historical approach of the investigation and review of the available research. The emphasis is on using documentation like articles, books and newspapers as
primary resources to reflect on everyday thinking and opinions around the identity of the traditional healer. The findings are represented in narrative format.

Results

The Traditional Health Practitioners Act’s regulations, as embedded in its 52 Sections, create a legal framework of definitions. One specific definition outlines what is meant by the traditional health practitioner. This definition includes four sub-types of healers, namely the diviner, herbalist, traditional birth attendant and traditional surgeon. Various other names for and types of traditional healers seem to exist outside the Act’s statutory definitions. It also seems as if the practice scopes, training and methods of diagnosis and treatments of these different healers are not uniform.

Conclusion

It seems that the legal definition of a traditional health practitioner, as offered by the Traditional Health Practitioners Act No 22, is vague and insufficiently formulated. This shortcoming frustrates the intention of the Act to make the traditional health practitioner the exclusive role player who has to deliver a traditional health service to the public.

Keywords

Afterlife, health establishment, medical doctor, medicine man, traditional doctor, traditional health practitioner, statutory

What this study adds:

1. What is known about this subject?

Literature bears evidence of different names to describe the traditional healer. There is no uniform understanding of this concept.

2. What new information is offered in this study?

There seems to be many more types of traditional healers than the four sub-definitions of the Traditional Health Practitioners Act No 22.

3. What are the implications for research, policy, or practice?

There is confusion in South Africa about who can and may call themselves traditional health practitioners. This will jeopardize the implementation of Act No 22’s.

Background

The primary intention of the Traditional Health Practitioners Act (Act No 22, 2007) is to regulate traditional healing in South Africa. The exclusive role player who has to deliver traditional health services to the public in terms of this Act is the traditional healer, called traditional health practitioner in the Act. This new term implies that the traditional health practitioner is now statutorily recognized as a health professional, similar to the medical practitioner. He or she will in time be allowed to practise this trade as a full medical partner in the formal health sector.1

When a new category of health practitioners apply for recognition to the Ministry of Health, these practitioners must offer evidence that their training has been established for many years, that it has a certified academic training system in place, that there is a need for and acceptance of these services and that the future continuation of the health profession is viable and sustainable. The statutory recognition of psychologists in the 1970s in South Africa is an excellent example of a successful application. A statutory mandate was only granted after the psychology fraternity offered constructive evidence, stretching over 50 years, of professional training courses executed by qualified staff at various South African universities and the existence of recognized professional programmes. This was supplemented a guarantee that the identity and entity of ‘psychologist’ has been established for many years and that the definition of a psychologist is familiar to the public and other health professionals. It was not an effort to register a range of unknown psychology types with names, training and scopes of practice that have never been described in psychology literature or that are unknown to the average citizen or to existing statutory health practitioners.2–8
Another excellent example of a clear definition of a health practitioner is that of the medical practitioner. The South African and international public and other types of healthcare providers all have a very clear and precise understanding of the definition of a **medical practitioner**, so much so that the courtesy title *doctor* has become embedded in the definition. Names such as medical doctor, general practitioner, surgeon and physician are synonyms of medical practitioner; meaning a health professional who is comprehensively and specifically trained to deliver a high level of comprehensive medical services and who is competent at all time.\textsuperscript{2-6}

One can assume that the lawmakers conducted an in-depth study of traditional healing before the definition of the traditional health practitioner was formulated and written into the Traditional Health Practitioners Act No 22 to establish statutory recognition. In supporting the definition, one can assume that the training, competence and the practice scope of the new traditional health practitioner were researched in depth and confirmed. This would enhance the use and acceptance of the term by the public and will help it enter the health establishment to facilitate cooperation with the other health practitioners.

The aim of the study was to determine if the definition *traditional health practitioner* denotes a single practitioner’s identity and entity and if it reflects a comprehensively skilled and competent professional in traditional healing. The statutory profiles and development histories of the psychologist and medical practitioner are used as guidelines to test the descriptiveness of the definition in the Traditional Health Practitioners Act 22 (2007) and to probe the comprehensive practise and know-how embedded in the definition.

**Method**

This study was done by means of a literature review. This method entails building a viewpoint based on research evidence. This approach is used in modern history research where information is scarce. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers and reports for the period 2003 to 2014, articles from 1993 to 2016, books for the period 1990 to 2013 and official documents covering the period 1999 to 2015. These sources reflect on opinions, viewpoints and thinking on the definition of the *traditional health practitioner*. The research findings are offered in narrative form.\textsuperscript{9,10}

**Results**

In light of the envisioned professional role and practice rights of the traditional health practitioner in the healthcare establishment, it is of utmost importance to determine a definition for *traditional health practitioner*. It is also pertinent to establish which training and skills and what practice scopes are embedded in the definition as described in the Traditional Health Practitioners Act No 22. An evaluation of the Act’s various definitions describing the traditional healer can elucidate this matter.

**The statutory definition of the traditional health practitioner in terms of Act No 22**

The person of the *traditional health practitioner* is prominent in Section 1 of the Traditional Health Practitioners Act No 22 (2007). This definition only reflects the single descriptive name *traditional health practitioner*, which refers to a person to be registered in one or more of four categories or sub-types of traditional healers. This description entails an immediate conflict with the definition of the medical practitioner, which does not include sub-categories of medical practitioners in its definition. The definition of the traditional health practitioner is purely an umbrella description and it is superficial and misleading. As the definition appears in the Act, it fails to stipulate who the traditional health practitioner really is. Legally and theoretically, the definition is only applicable when the healer is registered for all four the sub-categories at the same time. It also fails to define the scope of practice, training and the diagnosis and treatment approach of the traditional health practitioner. This incomplete definition compounds the registration problems with respect to the approximately 200,000 traditional healers. This presently unknown identity will surely also neutralize any cooperation within the healthcare sector.\textsuperscript{1}

**The statutory definitions of the four sub-groups of traditional health practitioners in terms of Act No 22**

There are four sub-groups of traditional healers that can be registered under the umbrella term traditional health practitioner. They are in fact the primarily role players in the delivery of the intended traditional health services and not the traditional health practitioner as reflected in the Traditional Health Practitioners Act No 22 (2007).\textsuperscript{1}

Sections 19(1) (c), 20(1) to 20(5), 47(f) (i) of the Traditional Health Practitioners Act No 22 of 2007 identify the four types as follows:
1. **Diviner**, meaning a person who engages in traditional health practice and who is to be registered as a diviner;
2. **Herbalist**, meaning a person who engages in traditional health practice and who is to be registered as an herbalist;
3. **Traditional birth attendant**, meaning a person who engages in traditional health practice and who is to be registered as a traditional birth attendant;
4. **Traditional surgeon**, meaning a person to be registered as a traditional surgeon.

The Traditional Health Practitioners Act No 22 again fails to describe the practice scopes, training and methods of diagnosis and treatment of the four categories in the descriptive wording of the four definitions. The description merely tries to associate the diviner, herbalist and traditional birth attendant with the definition traditional health practitioner with the wording “engage in traditional health practice” as reflected in Sections 19(1) (c), 20 (1) and 20 (5).

**Other official definitions of the traditional health practitioner in terms of Act No 22**

Other names allowed in terms of Section 49(1) (e) of the Traditional Health Practitioners Act No 22 in the place of the umbrella name traditional health practitioner seems to be traditional healer and traditional health doctor. These two official descriptions seem to be of limited value at the moment and only complicate the situation, seeing that they are synonyms for the term traditional health practitioner.

**Other common, but non-statutory names used for traditional healers**

Literature shows various other names for traditional healers in terms of abilities and tribal uses that are not mentioned in the Act. Some of these names are synonyms for existing names, while some describe unique types of healers.

These names are *ngaka chitja* (herbalist), *ngaka ea litaolo* (diviner), *ngakana-ka-hetla* (learner), *Mathuela, Moapostola* and *Pentecostal faith healers*. Other general names for the *diviner* are *sangoma* and *diagnostician*, while certain tribes identify the diviner with names like *izangoma* (Zulu), *amagqirha* (Xhosa), *ngaka* (Northern Sotho), *seloali* (Southern Sotho), *n’ango* and *mungome* (Venda or Tsonga). The *herbalist* is also generally named *inyanga*. In the Zulu culture they are known as *inyango*, while the Xhosas call them *ixhwele* and the Swahilis call them *mganga*. There are Christian practitioners also, called *faith healers* or prophets (known as *umthandazi* in Nguni and *umprofutzi* in Sotho). The traditional *birth attendants* are also known as traditional midwives or *ababelithisi*, while the *traditional surgeon* is known as *ingcibi*.

**Gumede’s various doctors of traditional healing**

The above-mentioned list of names goes further. The well-known South African traditional health expert, Gumede, identifies many other types of traditional healers (whom he calls specific “doctors in traditional healing”). The Traditional Health Practitioners Act No 22 fails to specify the different categories. According to Gumede, each healer’s group has its own function, with some dovetailing and overlapping.

Gumede identifies 20 types of traditional healers, each with a unique name:

**I Destructive and evil**

1. Abathakathi wizards
2. Witches

**II Diagnosticians or Diviners**

1. Izangoma, with types:
   a. Zamathamba (Bone throwers)
   b. Zehlonbe (Hand clappers)
   c. Zezabhulo (Stick diviners)
   d. Zegithupla (Thumb diviners)
(2) *Izanusi* (The smellers)

(3) *Abalozi* (Ventrilouquists)

(4) *Amandiki*

(5) *Amandowu*

**III Therapists**

(1) Medicine men (*Izinyanga zokwelapha* and *Izingedla*)

(2) Herbalists (*Izinyanga zamakhambi* or *zemithi*)

(3) Midwives (*Umbelethisi*)

**IV Specialists**

(1) Sky herds (*Izinyanga zezula*)

(2) Rainmakers (*Izinyanga zemvula*)

(3) Military doctors (*Izinyanga zembali*)

(4) Disease specialists (*inyangos*) with types:

(a) Chief special physicians

(b) Heart specialists

(c) Kidney specialists

(d) Chest specialists

**Mbiti’s medicine man and his other traditional healer types**

Mbiti\(^\text{16}\) offers further insight into traditional healer types. His book *Introduction to African Religion* does not make reference to the three sub-types of traditional healers of *herbalist, birth attendant* and *traditional surgeon* as the Traditional Health Practitioners Act No 22 (2007)\(^\text{4}\) does, nor does he refer to the term *traditional health practitioner*. He refers incognito to the Act’s herbalist as a *medicine man*, while he clearly, in addition to the *medicine man*, identifies the *diviner, medium, seer, ritual elder, religion leader, rainmaker* and *priest*. To a great extent his definitions of the different healers/religious practitioners are, like the definitions of the Traditional Health Practitioners Act No 22, also non-informative and contradictory and only contributes to a further confusion about the term *traditional health practitioner*. On the other hand, his definitions offer some useful descriptions of scopes of practice, treatment approaches and diagnoses.\(^\text{16}\)

Mbiti’s\(^\text{16, pp151, 155-56}\) definition of *medicine men* says the following on this person’s scope of practice, diagnosis and treatment approach:

“They carry out the work of healing the sick and putting things right when they go wrong. Their knowledge and skills have been acquired and passed down through the centuries; they are the ones who come to the rescue of the individuals in matters of health and general welfare. Major illnesses and troubles are usually regarded, treated and explained as religious experiences, while minor complaints like stomach upsets, headaches, cuts and skin ulcers, are normally treated with traditional medicines.

In persistent and serious complaints, the medicine man has to find out the religious causes of such illness or complaint which is usually said to be magic, sorcery, witchcraft, broken taboos or the work of spirits.

The medicine man prescribes a cure which may include herbs, religious rituals and the observance of certain prohibitions or directions. These measures also involve religious steps and observances. Therefore, the medicine man serves as a religious leader, who performs religious rituals in carrying out his work. Some medicine men are also the priests of their areas. They pray for their communities, take the lead in public religious rituals, and in many ways symbolize the wholeness or health of their communities.”
They deal in medicine, which means much more than just the medicine which cures the sick. It is believed that their medicine not only cures the sick, but also drives away witches, exorcizes spirits, brings success, detects thieves, protects from danger and harm, removes the curse, and so on.”

About the *diviners, mediums and seers*, Mbuti\(^{16,18-9}\) writes that these persons often work with the *medicine men* and they may even perform the duties of a *medicine man*:

- **Diviners** normally also work as *medicine men* and they deal with the question of why something has gone wrong. They can tell who may have worked evil magic, practiced sorcery or witchcraft against the sick or the barren, which spirit may be troubling a possessed person, what it wants and what should be done to stop the trouble. They discover the unknown by means of pebbles, numbers, water, animal entrails, reading the palms, throwing dice and many other methods. Sometimes, they get in touch with spirits directly or through the help of mediums. Diviners have knowledge of how to use some of the unseen forces of the universe.

- **Mediums** are people who make contact with the spirit world. They are often women and they are attached to medicine men or diviners. They can contact spirits at will, normally through ritual drumming, dancing and singing until they become possessed without being aware of it. Under possession they may do things that they may not do when their normal selves and they may communicate with the spirit world. Some mediums are possessed by only one particular spirit. They are said to be ‘married’ to it. Others may be possessed by any spirit. During their possession, they speak in a different voice and some of them may speak languages that they do not otherwise know. The diviner, medicine man or priest who is in charge of the medium, is then able to interpret what the medium is saying. Most of the communication through a medium comes from the spirit world to human beings, people rarely have messages to deliver to the spirit world. The medium tells people where to find lost things, who may have bewitched a sick person, what types of rituals and medicine are necessary to cure people’s troubles, whether an intended journey will be a success or not, which of the living dead may have a request to make and of what kind, and many other things.

- **Seers** are people who are said to have natural power by means of which they ‘see’ certain things not easily known to other people. Sometimes they foresee events before they take place. On the whole, there is no special training for seers. They are often people with foresight and insight into things. It is also possible that some receive revelations through visions and dreams, in addition to being able to use their intuition. Others have the ability to receive information through forces or powers not available to common man. Seers may be either men or women.

**Traditional surgeon**

Regarding the sub-category *traditional surgeon*, the Traditional Health Practitioners Act No 22\(^1\) again does not offer a description of its functions and roles. Nor do the writers Gumede\(^1\) and Mbuti.\(^{2}\)

The only reference to the practice and functions of the traditional surgeon in the literature up to 2016 comes from a group of South African scientists and public health experts. In a less flattering remark about the abilities of the traditional surgeon in the *South African Medical Journal* (SAMJ) of August 2014, they call for the banning of unsterile traditional male circumcision practices by traditional surgeons. These practices often cause death among the young men.\(^{24}\)

It was only in 2015 that the proposed Traditional Health Practitioners Regulations No 1052 (2015)\(^{11}\) officially referred to the traditional surgeon as a circumcision practitioner involved in initiation schools. This addition to the Traditional Health Practitioners Act No 22 will be valid as of 2016.\(^1\)

**Discussion**

It is clear that the various types and sub-types of traditional healers differ greatly and are sometimes quite distinct (including their methods and techniques, diagnosis and treatments, and their traditional formulations, muti and medical concoctions). The above analyses, evaluation and discussion shows that defining the *traditional health practitioner* is much more complex than what the Traditional Health Practitioners Act No 22 (2007) reflects in its definition.\(^{1,11,16,17,23,25-27}\)
Literature also reveals that the South African Ministry of Health itself acknowledges that there is a variety of healers that can confuse classification. They also admit that no groundwork has even been done to establish systematic approaches to the categories and their specialties. The legislation pertaining to traditional healers should make allowances for this. Lawmakers should take into consideration that the various undescribed categories of traditional healers could differ dramatically in functioning and skills from the statutory defined traditional health practitioner and its four sub-types of healers. These differences can even occur from region to region and clan to clan. It is clear that this differentiation should have been made when statutory recognition was bestowed on traditional healers in terms of the Traditional Health Practitioners Act No 22 (2007). Furthermore, the training of these types and sub-types must be characterized by the institutionalization of standardized training and qualifications before any trustworthy definition of the traditional health practitioner would be possible.\(^{17,28,29}\)

The name traditional health practitioner, as reflected in the Traditional Health Practitioners Act No 22 (2007), is defined in English. The same language approach was followed with the four categories of healers in the descriptions\(^7\). Considering the South African Constitution’s recognition of cultural uniqueness, these five legal definitions in Section 1 of the Traditional Health Practitioners Act No 22 do not meet the Constitution’s requirements of language and individual (cultural and tribal) rights. It also fails to acknowledge that each of the four official categories of traditional healers can be sub-divided into various other sub-types of healers with unique practice approaches, beliefs and customs, perhaps exclusive to a certain tribe or clan, region or group, as described by Gumede\(^17\), Mbiti\(^16\) and Pretorius.\(^17\)

First, traditional healthcare professionals have failed to provide evidence of their development. South African psychologists provided proof of 50 years of development to get statutory recognition as a health profession. Second, they have failed to thoroughly establish the identity and entity of the traditional health practitioner over years. They have not created an understanding of the definition of the traditional health practitioner with the public and among other statutory recognized practitioners like the medical fraternity that acknowledges the medical practitioner.\(^2,3,6\)

**Strength and limitations**

The research clearly shows that the Traditional Health Practitioners Act No 22’s statutory recognition of the entity traditional health practitioner is inappropriate and that the terminology is misleading.

A country-wide study of the various types of traditional health practitioners and workers, with a focus on their work, training and education and practitioner names, could aid the development of a clear and understandable definition and description.

**Conclusion**

It is clear that the present-day definition of the traditional health practitioner and the definitions of the four sub-categories of traditional healers as described in the Traditional Health Practitioners Act No 22 (2007)\(^7\) is incomplete, vague and misleading. It had failed the main aim of the Act, namely to define the profession traditional health practitioner, especially regarding its scope of practice. About 200,000 (or more) healers are awaiting registration. Describing each of the four subtypes or the many other types referred to in the literature, in terms of the Traditional Health Practitioners Act No 22 (2007), is going to take immense input and time. It will be impossible for the Interim Council to declare ±200,000 healers (of various healing, cultural, training and experience backgrounds) fit to be registered within the present classification, especially if this is expected in a short period of time. The Regulations No 1052 (2015)\(^11\), which is an effort to provide clarity on registration pathways for future traditional healers, also failed to solve the problem.

The traditional fraternity and the compilers of the Traditional Health Practitioners Act No 22 (2007) failed to offer a single acceptable definition or description of who the traditional health practitioner is. It is also clear that the practice, diagnosis and treatment styles and approaches of the various traditional healers cannot be embedded in a single identity as the Traditional Health Practitioners Act No 22 had tried to do with the definition of the traditional health practitioner. The inclusion of the traditional health practitioner in the country’s formal health establishment and its acceptance by the established medical fraternity as a profession in healthcare is at this stage clearly impossible.
Sound legal formulations and definitions of the various types of healers are needed before the Traditional Health Practitioners Act No 22’s definitions on the traditional health practitioner and its sub-types can be accepted as legal and as applicable to all traditional healers for registration. At the moment, the definition traditional health practitioner fails the test to pass as a uniform professional identity acceptable and useful for all the tribes or ethnic communities in South Africa.

The definition traditional health practitioner is undefined and insufficiently formulated. This inadequate definition jeopardizes the implementation of the Traditional Health Practitioners Act No 22 (2007) and the establishment of professional traditional healing in South Africa.

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(CHAPTER 3)

WILL THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) CHALLENGE THE HOLY GRAILS OF SOUTH AFRICAN MEDICAL DOCTORS


[Archives Australasian Medical Journal; Vol. 10 (2017), No. 2: Will the Traditional Health Practitioners Act (Act No 22, 2007) challenge the holy grails of South African medical doctors]
Will the Traditional Health Practitioners Act (Act No 22, 2007) challenge the holy grails of South African medical doctors?

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ABSTRACT

Background

The South African healthcare establishment is primarily managed and overseen by medical doctors. This powerbase was established over many years, especially after the early 1930s. World War II gave doctors the final approval to take this supervisory and sole decision-making role regarding healthcare training, practice models and other health workers in South Africa. This phenomenon led initially to doctors having a certain jurisdiction to set the pace and to make the rules.

This jurisdiction became more comprehensive and extent with time in South Africa to include a collection of unique medical traditions, customs, privileges, habits, healthcare rights and empowerment as well as exclusive medical training and practice models to become known as the holy grails of the South African medical doctors. The power of these holy grails has become untouchable to anyone outside the medical domain. Since the 1980s, some powers vested in these holy grails have been lost to the allied health professions and to other insiders of the HPCSA brotherhood itself.
The recognition of traditional healers by means of the Traditional Health Practitioners Act (Act No 22, 2007) seems to challenge these holy grails of medical doctors. This may also create internal conflict in the South African medical brotherhood that can cost medical doctors more ground.

Aims

The study aimed to determine if the Traditional Health Practitioners Act No 22 (2007) challenges the holy grails of South African medical doctors, subsequently affecting the long-established management and guardian system of the medical field within South Africa or the practice rights of medical doctors.

Methods

This is an exploratory and descriptive study that makes use of an historical approach by means of investigation and a literature review. The emphasis is on using current documentation like articles, books and newspapers as primary sources to reflect on the possible effect of the Traditional Health Practitioners Act No 22 (2007) and traditional healers on the holy grails of South African medical doctors. The findings are offered in narrative form.

Results

It is clear that South African medical doctors are still largely in charge of all healthcare management. This fraternity serves as gatekeepers in relation to what medical healers are allowed, the level of their training and even their future. Newcomers like the allied and traditional health practitioners are not easily allowed into the medical doctors’ domain.

Conclusion

The South African medical doctors’ interests as a specific healthcare provider group seem to be so well established that they give no thought to making dramatic changes to the present-day medical models and systems that they manage. They are not keen to relinquish any significant power as a group within the healthcare domain. This attitude means that the Traditional Health Practitioners Act no 22 (2007) can create enormous problems for South African medical doctors in future.

Key Words

Allied, allopathic, empowerment, healthcare, holy grails, jurisdiction physician

What this study adds:

1. What is known about this subject?

The powerbase and guardianship of the South African healthcare sector is seldom identified and described.

2. What new information is offered in this study?

The strong hold that medical doctors have over the country’s healthcare sector, including the other healthcare professions, is highlighted.

3 What are the implications for research, policy, or practice?

There are definite external and internal political, social, financial and healthcare factors that hold the potential to challenge, even to revoke, the privileged position of the medical doctors in a future South African healthcare system.

Background

The modern dominant role and position of South African medical doctors (and supported to a great extent by the dentistry profession) was established over years. It arose out of the European tradition of medicine and practice, which came to the Cape in 1652. It must be noted that the early training of European medical doctors, from which modern South African medical doctors and their training developed, was initially also a haphazard and unregulated affair. The same can be said of the professional status and empowerment of doctors in the early healthcare establishment. However, from the 1800s onwards, the curricula and formal examinations at European medical training schools had changed for the better and this new medical culture was transferred to the Cape by migrating medical doctors. In the 1900s, medical training and management progressed very fast. World War II brought a further new direction to scientific and medical developments and skills. This progress offered doctors a supervisory position in the health management of the country that has remained up to the present.1–5
WWII also brought practice challenges for medical doctors which they could not handle, especially with regard to rehabilitation. This sudden urgency and growing new demands forced South African medical doctors to outsource certain healthcare processes and deliveries. This outcome activated the recruitment of other healthcare providers with the recognition of auxiliary health practitioners, like psychologists, physiotherapists, etc.\textsuperscript{2,6–9}

These new healthcare intakes, the management of their practices, empowerment, training abilities, skills and rights, were under the sole supervision of the growing number of South African medical doctors’ right from the beginning. This is still the situation today. It is within this context of the medical doctors’ superior training, skills and abilities, supposed cognitive and personal giftedness, extraordinary leadership, supervisory and executive talent in healthcare and social management, wise decision making regarding healthcare and personal matters, and the perception that they are the savers and givers of health and life, that their holy grails became established and flourished over time, accompanied by a manifold of specific and unique medical rights and privileges. This progressed over time to form part of an exclusive, closed socio-political, professional and legal unity, the brotherhood of South African medical doctors, nearly untouchable to the outsider.\textsuperscript{2,6–9}

The recognition of other health professions as part of the healthcare system started a slow dismantling of medical doctors’ role as supervisors and leaders of the South Africa’s healthcare establishment. The medical auxiliaries slowly mastered more and more skills and their practice empowerment enlarged. These healthcare professionals developed the need for independence, although still overseen by the Healthcare Professional Council of South Africa (HPCSA). They slowly created their own professional bodies under the auspice of the HPCSA. This dismantling of the guardianship and leadership of medical doctors in the formal South African healthcare sector was exacerbated by the entry of the various allied healthcare professions. This is a process that is still ongoing today, signaling an increasing loss of specific jurisdiction inside their holy grails for medical doctors in South Africa.\textsuperscript{2,6–9}

The above process has activated a dormant internal conflict in the South African medical power relations. This conflict started in the old South African Medical and Dental Council (SAMDC) and was transferred to its successor, the Health Professions Council of South Africa (HPCSA). This conflict is further aggravated for the South African medical doctors by the Allied Health Professional Council of South Africa (AHPCSA) and its various allied healthcare practitioners, like the homeopathic, osteopathic and chiropractor doctors.\textsuperscript{2,6–9}

A further newcomer to the scene is the Traditional Health Practitioners Act No 22 (2007) and its traditional health practitioners, challenging the holy grails of South African medical doctors even more.

The study aimed to determine if the Traditional Health Practitioners Act No 22 (2007) will challenge the holy grails of South African medical doctors, affecting their long-term management and guardianship of the formal South African healthcare sector.

Method

This research was done by means of a literature review. This method is aimed at building a viewpoint based on available evidence as research on the subject developed over time. This approach is often used in modern historical research where there is a paucity of information. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for the period 2014, articles from 1976 to 2016, books for the period 1978 to 2013 and government documents covering the period 1974 to 2007. These sources enable reflection on the development and functioning of the Traditional Health Practitioners Act No 22 (2007) and the holy grails of South African medical doctors as it developed over centuries in the country. These sources also put into perspective the thought and opinions on traditional healers as role players in the present formal South African healthcare sector, endangering the holy grails of medical doctors.\textsuperscript{10,11}

The findings of the research are presented in narrative form.

Results

The allied health professions and the first loss of holy grails by the South African medical fraternity

It is clear that medical doctors (and to a certain extent dentists by means of their inclusion in the Professional Board for Medical Doctors and Dentists) became the holders and bearers of the healthcare authority over the years, starting in the 1900s. They did not easily allow influences or disruptions from outside that would influence their right to manage, steer, plan, lead and execute in the formal healthcare sector. This status quo was disturbed in the 1950s by the South African supplementary or alternative health groups (today’s allied health practitioners) who
started to demand statutory recognition, independent from the SAMDC of that time. The medical fraternity initially dealt with this competitor strictly. South African medical doctors declared in 1953 through the Medical Association of South Africa (MASA), that the allied/alternative health fraternity was unscientific and illegal. Provisions were even included in the medical code of the South African medical doctors to prohibit cooperation with allopathic and alternative practitioners.1,3,12

However, in 1982 the medical doctors of South Africa lost some of their power when the Allied Health Professions Act No 63 (1982) made provision for the regulation of the allied health professions with their own Council (AHPCSA). This council is independent from the guardianship of the Health Professions Act No 56 (1974), which up to that point regulated all the medical professions and auxiliary medical professions under the sole auspice of the South African medical doctors. These alternative health practitioners are fully active in the formal South African healthcare sector today. However, they are a fringe group that occupies less than 5 per cent of the total healthcare market. Thirteen disciplines are currently registered with the AHPCSA, all of them already claiming their own holy grails.1,3–5

It must be noted that notwithstanding their five-year medico-scientific training for the MTech (Homoeopathy) degree offered at two South African (SA) universities, homeopaths are still side-lined in the South African formal healthcare, especially by medical doctors. The allopathic fraternity still describe homeopathic medicines as placebos and homeopathic treatment as a risk for human life. Allied healthcare practitioners are still not generally allowed as members of the public health establishment, but are mostly restricted to private practice.13–22

Silent conflict inside the HPCSA brotherhood

Over the years, there has been conflict about professional practice rights and status and the limitation on training and the obtaining of specific skills and abilities inside the HPCSA brotherhood. This conflict is even more masked than that between the medical doctor and the allied doctor. There are inside fights between pharmacists, as professionals registered with an independent council (The Pharmacy Act no 53, 1974), and the right of medical doctors to treat patients directly and to prescribe medicine. In addition, there has been a dogfight over the years between psychiatrists and psychologists for professional self-empowerment. Psychiatrists view certain categories of psychology (educational and industrial) as insufficient to treat adult patients with serious emotional problems. This reflects how the holy grails of medical doctors are endangered inside the HPCSA. The in-fights between the different categories of psychologists registered with the Professional Board of Psychology, which forms part of the HPCSA, about certain medical holy grails transferred to them over time by medical doctors are more intense than reflected to the public. This again confirms not only the down-scaling of the medical holy grails of South African medical doctors, but also that of the HPCSA as formed and guarded by South African medical doctors.8,9,23–28

Possible future impact of the Traditional Health Practitioners Act No 22 (2007) on the South African medical doctors and their holy grails

The arrival of traditional health practitioners as another independent group of health practitioners in the formal South African healthcare sector, totally free from the resolutions and implementations of the Health Professions Act No 56 (1974) and the South African medical doctors guardianship as applicable to all the professions inside Act No 56 of 1974, is a dynamic development that can trigger immense changes for the medical doctor.29

The Traditional Health Practitioners Act No 22 (2007) directly and openly aims to give traditional health practitioners the same statutory status as that of the allopathic health practitioners in the formal healthcare sector - including public hospitals. Public hospitals used to be the exclusive domain of medical doctors because of their specific and extraordinary training and skills. The traditional health practitioners’ substandard training, skills and their strong religious inclinations may put medical doctors under new pressure in respect of their holy grails. It seems in this context as if the Traditional Health Practitioners Act No 22 and the incoming traditional health practitioners pose much more danger to the holy grails of medical doctors than the allied health professions did in 1982. This includes their practice rights, privileges and status, as well as their executive and guardian power.29

Two prominent issues can be fore-grounded. First, the pre-modern methodology of traditional healing spells direct and indirect disaster for the official South African health establishment. It directly threatens the regulated medical doctors’ position and status as main healthcare providers and healthcare executives in South Africa. Second, the recognition of traditional healers seems to have other serious consequences. The HPCSA specifically and the power of the different professional bodies are endangered.
South African medical doctors are concerned not only about losing more of its dominant role in the overall South African healthcare sector, but also about losing its internal authority over the other regulated, but subordinated professions within the HPCSA brotherhood. This means a further loss of holy grails and a leveling of professions, both within and outside the HPCSA brotherhood. The South African medical doctors fiercely opposed this situation in the past to keep their holy grails intact.30–33

For South African medical doctors with their established ethics, traditions, training and professional standards, these various newcomers in healthcare are nothing else than modern imposters with the sole intention to take over parts of the medical holy grails, notwithstanding their seemingly sound arguments and pleas that they are skilled “medical doctors” who are able to deliver comprehensive medical diagnoses and treatments.30–33

The above demanding situation requires a choice between adapting and dying for medical doctors. In the past they could deflect all threats as they had political and social favour. In New South Africa, this support system is weak, even hostile sometimes. Revisiting and evaluating their holy grails become unavoidable for South African medical doctors.

It is also worthwhile to note in this regard that after the 1990s medical doctors again lost some ground when the SAMDC, which conferred enormous power on the medical profession, was replaced with the more democratic HPCSA. In the HPSCA the different professional bodies were empowered, empowering the so called auxiliary medical practitioners.4

Another important outcome of the Traditional Health Practitioners Act No 22 (2007) is the right of traditional healers (including White traditional healers that are becoming prominent) to prescribe medicinal mixtures and mutis. This outcome, although possibly not intentionally intended by the Traditional Health Practitioners Act No 22 (2007) to influence the allopathic doctors maliciously, can restart, as previous already indicated, a long-time lingering conflict inside the already regulated health professions within or outside the HPCSA. The prohibition of psychologists, pharmacists and nurses to prescribe independently medicines are of particular relevance. It is a problem that has been demanding attention since the 1970s, but it was put aside and neutralized, first by the SAMDC and later by the HPCSA, as part of the dominance of the medical doctors (and to a certain extent the dentists).

Losing such exclusiveness on practice rights would mean the direct collapse of the South African medical doctors’ holy grails.25,27,28,34–37

The various resolutions of the Traditional Health Practitioners Act No 22 (2007) and its future legal and professional implementation can cause widespread disruption and conflict inside the HPCSA itself. It can lead to sudden and unexpected challenges for medical doctors, challenges they have never had to deal with before and that they are not geared to face with effective constructive counter-actions.25,27,28,34–37

One example is the future position of psychologists as equal members with the medical doctors and dentists in terms of the resolutions of the Health Professions Act No 56 (1974) and not as auxiliary healthcare practitioners. They are also both equal to the untrained traditional health practitioner who is now allowed to prescribe traditional mixtures to treat mental problems. The fact that psychologists, who are in possession of recognized Master’s degrees in psychology with many psychologists also obtaining qualifications in pharmacy, anatomy and physiology and doctoral degrees in Psychology - are still prohibited from prescribing any medicine, notwithstanding their clear position in terms of the Health Professions Act No 56 (1974), is creating more and more tension. The traditional health practitioners’ right to make and prescribe medicines spells conflict. Also the right of the traditional health practitioners to be called the courtesy title doctor (as with all the allied health professions of South Africa), while the psychologists registered in terms of the Health Professions Act No 56 (1974) as equal to the medical doctors are not allowed this privilege (only with a real doctorate), reflects discrimination towards the psychologists inside the HPCSA. Together the psychologists and the traditional health practitioners can form a future.

It is clear that the Traditional Health Practitioners Act No 22 (2007) can activate shifts in professional registrations. Psychologists can for instance move away from the HPCSA and Board of Psychology to registrations as traditional health practitioners with the Traditional Health Practitioners Council of South Africa (THPCSA). It is an open question why psychologists would stay in a registration and with a council/board that limits their practice rights and privileges just to benefit the South African medical doctors. Why would they keep to “talking therapy” when they can also practice “pill therapy” and maximize their practice skills and income like the traditional health practitioners intend to do?
If the Interim Council of Traditional Health Practitioners recognizes the dilemma that the Traditional Health Practitioners Act No 22 (2007) can create for the already-regulated health boards inside the HPCSA regarding their limited and the discriminating practice rights and privileges, they can use this dilemma as an opportunity to recruit regulated practitioners like the psychologists, the pharmacists and the nurses from the HPCSA and the Pharmaceutical Council of South Africa and the Nursing Council of South Africa as traditional healers. They can strengthen their professional position. Such recruiting can offer them established manpower, leadership and a powerful direction, far away from the restrictions of the present. It can change the face of the South African professional healthcare and delivery dramatically.

The South African Healthcare Acts and the upkeep of medical holy grails

It is of utmost importance that the South African government also revisits the country’s various health acts. This includes the South African Pharmacy Act (No 53, 1974), the Health Professions Act (No 56, 1974) and the Nursing Act (No 33, 2005) to see if they are still applicable to the South African scenario and the needs of present-day South African patients. It is also of importance to consider the rigid authority of medical doctors, which exclusively favours the South African medical doctors in the formal healthcare sector. If the government could inaugurate and implement the Traditional Health Practitioners Act No 22 (2007) despite the opinions and will of the regulated health professions, especially the dominating medical doctors inside the HPCSA, what would stop the government from revising all acts on health, pharmacy and the nursing professions to give the regulated practitioners greater practice rights and to diminish the authority of the South African medical doctors?

Better health service can be offered if the South African government changes the rule that only the medical and dental practitioners may prescribe independently, especially in rural areas. Effective healthcare professionals can then take over this task from traditional health practitioners.

New generation of mental health professions

The fact that more than 30 per cent of the total South African population experiences mental health illnesses and that 75 per cent of them will never receive any psychological and psychiatric treatment, while in the public health sector up to 80 per cent of these cases are neglected, has brought about a change in the minds of some South African medical doctors, although a minority group, regarding the psychologist, pharmacist and nurse’s right to prescribe. The fact that the modern medical doctors’ ratio to patients is only 0.8 per 1,000 (against the WHO ideal ratio of 1.67 per 1,000), makes the dispensing training of the psychologist, pharmacist and nurse enticing.

It is in this context that traditional healers are starting to make inroads into the formal healthcare sector through the Traditional Health Practitioners Act No 22 (2007), even though it is minimal at the moment.

It is of great interest to note that the USA has already started to empower psychologists to dispense. In two US states, New Mexico and Louisiana, some psychologists with post-doctoral pharmacology training, have been granted prescriptive authority for certain mental health disorders upon agreement with the patients’ physician. Medical doctors in South Africa would have to consider such an option if they want to still be in the health domain in 10 or 20 years from now and they want to keep their holy grails.

This is a hope that can be disappointed by the entry of traditional healers. Is it not time for new healthcare professionals and health training, like the psychosician (psychologist-psychiatrist inbred), pharmacist-diagnostician and the nurse-diagnostician? Is it not time to merge the pharmacist and the naturopath/homeopath/phytotherapist (herbalist) of the allied professions? The medical doctors must accept that changes to its system and models are unavoidable. Its present practice models are not affordable anymore for the poor of South Africa

Discussion

In South Africa, authority in the medical and healthcare environment is still mostly the prerogative of modern-day medical doctors who are still embedded in not only their “on top” and “on tap”-status, but also to a certain extent by some with financial self-interest that make them blind for local and international changes in the types of healthcare practitioners available, their training and their new empowerment. It also missed out many medical doctors that their traditional established training and professional model, giving them their powerbase in the past, is undergoing fast enormous changes and recalling in developed countries. This is a situation that will surely be
followed in South Africa in a decade or two. Changes in the mindset of the present-day medical doctor regarding power division, status, exclusive practitioner rights and financial self-enrichment, cannot be delayed or ignored. It must be noted that the present South African government’s attitude towards an exclusive European/Western context and doings in medical care and management, are indeed changing. Sometimes this is very noticeable, but mostly it goes unnoticed. The South African government’s political dimensions have broadened as a result of its admission to the BRICS Alliance, a group with its own, unique approaches to medical training and models, as the People’s Republic of China has already demonstrated. South Africa’s friend, Cuba, has already given us a good lesson on how effective medical training can be different from ours, yet be done on a great scale. Forced changes to the system and models of the South African medical establishment can and may happen surprisingly fast in the near future. It will therefore be wise for the South African medical doctors to be prepared and to act preventatively.

It is better for a profession to change positively than to be forced backwards, a negative situation that the South African medical doctors is seemingly slowly starting to slide into. The negative actions aimed at the modern health sector by means of the Traditional Health Practitioners Act No 22 (2007) and due the present government’s dislike for the European/Western health establishment, are strong destructive indicators for the holy grails of medical doctors.4,25,27,29–37,42–53

The Traditional Health Practitioners Act (Act No 22, 2007) is far more complicated and powerful than what the South African healthcare administrators, the public and the regulated health professions think. As said, the Act can have far-reaching effects on the future of the healthcare sector and its regulated health professionals in South Africa beyond its recognition of the pre-modern traditional healer and his practice. It is undoubtedly going to challenge medical doctors, both directly and indirectly.

Strengths and limitations

There is a paucity of South African studies that focus on the power of medical doctors. This study does so, specifically by looking at the possible future impact of the traditional healer and the Traditional Health Practitioners Act No 22 (2007) on their holy grails.

Conclusion

South African traditional health practitioners can, with their masked African identity and superficial indigenous-cultural distinctiveness and political favouring, become a well-planned stimulus to destroy the position of medical doctors in the South African healthcare society. This negative impact can also destroy the medical holy grails of the modern medical doctors; especially the degree of power and rights of the medical doctors of South Africa. The Traditional Health Practitioners Act No 22 (2007) is a confrontational piece of legislation, intended to take on the South African medical doctors and their authority.

The authors believe that the Traditional Health Practitioners Act No 22 (2007) will challenge the holy grails of South African medical doctors, affecting their long-term management and guardian system and their exclusive practice rights within the formal South African healthcare sector.

We also believe there are other role players, some even within the HPCSA brotherhood, who may support the Traditional Health Practitioners Act No 22 (2007) in its aim to take over the holy grails of the South African medical doctors, fully or partially, in the near future.

It is time that South African medical doctor’s look in the “mirror” to revisit their power, privileged rights and dominant position in the South African formal healthcare sector. They should devise a strategy to ward off the intrusion of traditional healers of their holy grails.

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THE UNWRITTEN NEW PRACTICE RIGHTS OF THE TRADITIONAL HEALTH PRACTITIONER AS STIPULATED BY THE TRADITIONAL HEALTH PRACTITIONERS ACT (22 OF 2007) OF SOUTH AFRICA


[Archives Australasian Medical Journal; Vol. 9 (2016), No. 11: The unwritten new practice rights of the traditional health practitioner as stipulated by the Traditional Health Practitioners Act No 22 (2007) of South Africa]
The unwritten new practice rights of the traditional health practitioner as stipulated by the Traditional Health Practitioners Act No 22 (2007) of South Africa

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ABSTRACT

Background
In 2007, a practice directive was issued for the new legal entity traditional health practitioner with the promulgation of the Traditional Health Practitioners Act (No 22 of 2007) in the Republic of South Africa. Although the Act describes this new pathway in terms of various definitions, the future practice rights and impact on healthcare were left undefined and unwritten. To date the negative legal implications and career consequences that the Act has for the regulated health practitioners, have gone unnoticed. The derogation and degrading of their work domains and rights, seem of no concern.¹

Aims
The aim of the present study is to determine and describe the unwritten new practice rights of the traditional health practitioner.
Methods
This is an exploratory and descriptive study in line with the modern historical approach of investigation by means of a literature review. The emphasis is on using documentation such as articles, books and newspapers as primary resources to reflect on the traditional health practitioner’s new unsaid and unwritten future practice rights.

Results
The future practice and services of traditional health practitioners seem to incorporate many new unwritten practice rights and activities, which is contrary to the Act’s written intentions.

Conclusion
The new traditional health practitioner’s future practice rights are legally comprehensive and masked. It holds serious consequences for the practices of the established healthcare professions.

Key Words
Allopathic, body-mind dichotomy, health establishment, holistic unity, mental-physical, legal entity, mental illness, physical health, well-being

What this study adds:

1. Information on this subject?
   Limited information and guidelines are available on the future practice rights of traditional health practitioners, especially critical descriptions of the intentions of the Traditional Health Practitioners Act No 22.

2. What new information is offered in this study?
   The study clearly describes the future unwritten practice rights of the traditional health practitioner.

3. The immediate implications for policy and practice?
   There should be more thorough research on the future practice rights of the traditional practitioner in terms of Act No 22 (2007) and established healthcare practitioners must be educated on the negative implications this has for them.

Background
The new policy of 2007 to regulate traditional health practitioners with the Traditional Health Practitioners Act No 22 (2007) awarded these practitioners immense legal rights to practice. Some new activities, rights and privileges are clearly mapped out, others not. Before this Act there was no legal framework according to which to regulate and register traditional healers in South Africa. Training and education are non-existent, as well as an ethics code of professional conduct and a professional position as a practitioner in the established healthcare sector.¹

Although already promulgated in 2007, the Act has only been partially enacted in 2016. Its contents and intentions are largely unknown to established healthcare practitioners and the general public.¹

This outcome is that regulated practitioners do not always understand or have a correct legal interpretation of the future implications of these new practice rights for the healthcare establishment. The various definitions and accompanying descriptions have not been thoroughly analysed and relayed to the other pieces of healthcare legislations that govern the medicine, pharmacy, nursing and the allied professions. This ignorance can have serious consequences for the country’s healthcare management and planning.¹

The aim of this study was to describe the new unwritten practice rights that can arise from the 2007 legislation on traditional healthcare.

Method
The research was done by means of a literature review. This method involves developing a view based on the available body of research. This approach is frequently used in modern history research where information is scant. The databases used were EBSCOHost, Sabinet online and various contemporary sources like newspapers for 2014,
articles from 1980 to 2016, books for the period 1990 to 2013 and government documents covering the period 1992 to 2008. These documents were studied to reflect on the traditional health practitioner’s new unwritten practice rights. The findings of the study are offered in narrative form.2,3

Results

The holistic unity versus the body-mind dichotomy

The compilers of the Traditional Health Practitioners Act (No 22, 2007) attempted to assure regulated healthcare professions by means of different stipulations that the Act will not violate their existing practice rights and privileges when fully enacted. Three legal definitions, namely traditional philosophy, traditional medicine and traditional health practice are offered as a safeguard, with the prefix traditional as a prominent addition.1

However, viewed on the whole, the Act seems to actually contradict this safeguard. The prominent use of the term traditional in the first part of the Act, while this adjective is largely missing in the second part, is an anomaly.1

This contradiction is further aggravated by the misuse of the popular view of traditional health practice as a holistic unity that involves a holistic physical, spiritual and well-being approach to the human and his illnesses. Act No 22 (2007) shows that it underwrites a body-mind dichotomy. There is a clear description on the one hand of physical illness and of mental illness on the other hand in the discussion of the diagnosis and treatment approach. This practice differentiation most strikingly comes to the fore in the legal definition “traditional medicine” in Section 1 and Section 49(1) (b) of the Act1. Other literature confirms this observation.4-6

The traditional healers’ new practice rights are in conflict with their customary holistic sickness approach to diagnosis and treatment. The holistic inclination sees the supernatural primary as the reason for illness. This used to be the main argument to regulate traditional healers, but traditional healers’ practice rights have now been extended to meet the rights and privileges of regulated healthcare professions that base their approaches on a body-mind dichotomy. This outcome was unopposed, notwithstanding the fact that the qualifier traditional in the three legal definitions is supposed to limit the traditional health practitioner’s rights to traditional procedures only.

The conjunction “or” instead of “and” to differentiate between physical and mental in the legal definition of traditional medicine of Sections 1 and 49(1) (b), changes the emphasis of the stipulations regarding practice rights. The emphasis is completely different from the universally and traditionally accepted holistic descriptions of traditional healing that do not separate the natural from the spiritual or the physical from the supernatural.1,7

The emphasis in the Act has changed the practitioner’s traditional role as diagnostician. Traditionally, he or she was assumed to have received supernatural powers, either through heredity or from his ancestors, to identify reasons for unnatural illness and unfortunate events, and to mediate with the spirits about the wishes of the living.5,8,9

The practice directive of traditional philosophy as legally defined in the Act stands in contrast to the new trend of exclusively physical diagnosis and the use of muti to treat illnesses directly and separately. This is not traditionally associated with the rights, traditions or skills of the South African traditional healer when viewed as a supernatural holistic unity. In contrast to custom, Section 49(1) (b) very selectively terminates the limitation “not to may and not to can” venture into the sole treatment of physical illness.4,8-12

The delimitation of the holistic unity

Section 49(1) (b) not only nullifies the traditional healer’s holistic practice uniqueness, but also quietly and selectively terminates in total the limitation of the prefix traditional in the legal descriptions of the Traditional Health Practitioners Act No 22 (2007).1

It is important to revisit Section 49(1) (b) to understand how it violates the practice rights and privileges of the regulated health professions.1

The specification or physical health and or mental health as separate practice entities and as specific new practice rights are prominent. There is not a single reference to traditional in Section 49(1) (b). Indeed, the traditional healer’s infiltration into the modern healthcare sector is not even masked behind the prefix traditional, as was done in the earlier Sections of the Act.1

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These earlier references successfully distract the attention away from the Act’s real intention, namely to declare the new legal entity, traditional health practitioner, a type of medical practitioner or medical doctor and to bring the healer as an equal of the medical doctor directly into the health services and health establishments of the country.\textsuperscript{1}

**Other masked intentions of Act No 22, 2007**

Two legal definitions, namely health establishment and health services, foreground the masked intention of the Traditional Health Practitioners Act No 22 (2007) to empower the traditional health practitioner within the formal healthcare sector.

The inclusion of the clause health establishment in the Act clearly provides the traditional healer with direct entrance to “may and can” practice in any public or private institution, facility, agency, building or place or part thereof, that provides health services.\textsuperscript{1}

This inclusion of the clause health service gives the traditional health practitioner the right and privilege to offer health services inside any of the above official health service establishments. This service can indeed include inpatient and outpatient treatment, diagnostic or therapeutic interventions, nursing and rehabilitative, palliative, convalescent and preventative health service.\textsuperscript{1}

The inclusion of the legal definition of the Department of Health in the Act aims to bring traditional health into the private and public health services and health establishments of South Africa. This is clearly part of a long-term political plan, which started in the 1960s.\textsuperscript{13–23}

This intention of the government was openly stated in public by a Deputy Minister of Health, Gwen Ramokgopa, in 2013 when she acknowledged the plan of the government to integrate traditional healers into the healthcare establishment. She confirmed that many primary healthcare facilities and hospitals are already working in collaboration with traditional health practitioners and that they are members of Clinic Committees, Hospital Boards, District Health Committees, Provincial and National Advisory Structures with government approval.\textsuperscript{24}

Ramokgopa’s remark is in line with other government efforts from the 1990s onwards to topple the medical doctor from his central healthcare position by inserting various community healthcare workers, like traditional healers, into the system so that they are “on top” and “on tap”.\textsuperscript{17–20,25}

**More new rights and entitlements**

The limitations that are enforced in the first part of the Traditional Health Practitioners Act No 22 by means of the legal definitions traditional medicine, traditional health practice and traditional philosophy are virtually erased by three legal definitions. They are not qualified by the adjective traditional and they are health establishment, health service and Department of Health.\textsuperscript{1}

This is amplified by Section 42(2), which opens the door to health services and establishments by providing for claims of payment to traditional health practitioners from Medical Schemes in terms of the Medical Schemes Act No 131 of 1998.\textsuperscript{1,26}

Section 44(2) states that no person other than a traditional health practitioner, registered in terms of the Traditional Health Practitioners Act No 22 (2007) and holding the necessary qualifications, is eligible for or entitled to hold any appointment to any establishment, institution, body, organization or association, whether public or private, if such appointment involves the performance of any act which only a traditional health practitioner, in terms of Act No 22 may perform for gain. This creates an open-door policy with regard to hospitals and other institutions. It also states that nothing in Section 44(2) precludes the training of traditional health practitioners or students under the supervision of a suitably qualified traditional health practitioner, or the employment in any hospital or similar institution of any person undergoing training with a view to registration in terms of the Traditional Health Practitioners Act No 22 under the supervision of a suitably qualified traditional health practitioner or other health professional.\textsuperscript{1}

The new status of the traditional health practitioner as a new kind of medical doctor with the annulment of the prefix traditional in various legal definitions and descriptions in the Traditional Health Practitioners Act No 22 (2007), is also reflected with Section 49, which puts in place various rights of practice. Included here are various unwritten practice rights. Section 49 has serious consequences for the regulated health professions and holds
enormous risks for public health. It also discriminates against the healthcare professions such as psychologists, pharmacist and nurse by bestowing various practice rights on the \textit{traditional health practitioner} that are totally denied to these professions.\footnote{1}

Section 49 is further confirmation that government will merge the \textit{traditional health practitioners} - with their comprehensive new written and unwritten rights to practice - as fast as possible with the public health sector and that they will not consider back-tracking on the Traditional Health Practitioners Act No 22 (2007) at all.\footnote{1,7}

\textbf{Is unprofessional conduct equal to professional ethics?}

Government’s official sanctioning of the rights of practice of the \textit{traditional health practitioner} is further extended with the definition of professional conduct. It is implied in the definition of \textit{unprofessional conduct}, which reads: “any act or omission which is improper or disgraceful or dishonourable or unworthy if the traditional healer performs or do it”.\footnote{1} This sanctioning is regardless of the clear lack of medical training and healthcare standards and ethics among traditional health practitioners.

The above legal definition is specifically applicable to the legal definition \textit{traditional health practice} in Section 1 of the Traditional Health Practitioners Act No 22 of 2007 (read together with the three legal definitions \textit{traditional health practitioner}, \textit{traditional medicine} and \textit{traditional philosophy}) to guide the traditional healer’s ethics in his so called \textit{traditional practice}.\footnote{1}

Professional conduct, and its upkeep by the traditional healer, takes on new meaning given the goal of the Department of Health (DoH) to make traditional healing a full public health service as part of all the health services and in all the establishments of South Africa. This potential for misconduct is increased by Section 49’s attempt to make the traditional healer a full member of the established group of regulated health professions and to grant the healer comprehensive rights and privileges of practice as part of the official health services and in establishments.\footnote{1}

Improper conduct is eminent with the 200 000 traditional healers waiting to be registered in the near future. They will legally be health professionals without any formal or recognized medical training, experience and skills, and a lack of exposure to modern health facilities. They will be free to heal under their new statutory registration. The pre-modern \textit{traditional client} now becomes a \textit{modern patient} within the structure of medical schemes and health establishments. The modern patient is in other words unwillingly transferred to the \textit{traditional health practitioner}’s pre-modern traditional health services at public and private facilities. This not only strengthens the traditional healer’s new practice rights, but extends them beyond limit, specifically the unwritten rights.

The above imbalanced empowerment and extreme favouring of the \textit{traditional health practitioner} in the country’s health establishments, is in contrast with the trained homeopathic doctor, who is currently not included in the public health initiatives of the country and whose services and rights of practice are predominantly limited to the private healthcare sector.\footnote{27}

The move of traditional health services to a modern, formal \textit{in-patient} and \textit{out-patient hospital setup} is very different from the present practice setup, practice rights and scope of services of the traditional healer. In the traditional context an \textit{in-patient} lives at the traditional healer’s home for the duration of treatment. The \textit{out-patient} is visited by the traditional healer, and sometimes the healer stays at the patient’s home to give treatment.\footnote{4} It is probable that these pre-modern consultations, rituals and customs of the traditional healers will become part of the established modern healthcare tradition. Gumede\footnote{4} refers very honestly to this when he says: “Consultations take place not in the sterile meaningless environment of the hospital, but at the patient’s home in the environment which is not only familiar but where the problem is and where the living dead will hear the incantations to their persons. They smell impepho and see the sacrificial beasts and roar approval as the goat bleats or the bull bellows when slaughtered” (p. 19). There are undoubtedly new unwritten practice rights that will be activated for the traditional healer, not only inside the formal healthcare setup, but also outside the formal healthcare setup, since the healer can enforce his practice rights on the modern patient.

The introduction of the practice services of the \textit{traditional health practitioner} into the modern health practice and sector may possibly see the replacement of the white coat and stethoscope of the medical doctor in operating rooms and surgeries by the traditional health practitioner’s pre-modern attire, consisting of bandoliers, a sangoma hairdo tagged with gall bladders, a head-umyeko of beads, a sangoma-stick, a “doctor’s bag” consisting of horns filled with concoctions, a broom to sprinkle charm-medicine, an ox-tail as a diving ward and a skin bangle of a sacrificial beast to assure victory over illness.\footnote{4}
The above possibilities not only means that these healers can put thousands of innocent lives at health establishments in danger because of their lack of medical knowledge and skills, but also that the ethics and rules of the hospital and patient, as well as the rules prescribed for the healer, can be transgressed. The so-called “good” professional conduct of the traditional health practitioner, as envisaged in Section 1, can change very fast to “acts or omissions which is improper or disgraceful or dishonourable or unworthy for the traditional health practitioner”, when the traditional healer enters the modern health establishments with his controversial health services, habits and customs, together with his new unwritten rights of practice.\(^1\)

**Other new, exclusive practice rights and privileges**

Section 49 further benefits the traditional health practitioner regarding his rights of practice, both legally defined and unwritten. It prohibits the regulated health professions from practicing in any of the physical and/or mental health areas of the traditional healer; identified with the misuse of the qualifier traditional. Only medical practitioners and dentists are exempted by Section 49(5).\(^1\)

The domain of practice bestowed on the traditional healer in terms of the above different rulings, especially Section 49, means that the traditional health practitioner, now with the title “doctor”, can apply and prescribe, in terms of the unwritten rights, any form of traditional “medicine” or concoctions to patients, inside or outside health establishments.\(^1\)

The treatment of HIV/AIDS and cancer is now, in terms of Section 49(g), also in the practice domain of the traditional health practitioners, notwithstanding their lack of training and their bad reputation when it comes to treating these diseases.\(^10,21-28\) This situation will surely be exploited by the traditional healer.

**Discussion**

The above outcomes are good examples of how the compilers of the Traditional Health Practitioners Act No 22 (2007) misguided the practice rights of the traditional healer with faulty legal definitions that they derived from the different regulated health professions acts. The legal guidelines and support fail to compensate for the traditional healer’s lack of scientific training, health principles and ethics, as well as his inability to offer trustworthy health practices. Notwithstanding this failure, the traditional healer’s practice is legalized by the Act, resulting not only in a contamination of future legal and written practice rights, but also of the unwritten future practice rights.

The traditional health practitioner, in his effort to formulate a professional code of conduct and to gain a status as a respected health practitioner, failed, basically because the legal definition traditional philosophy is his main directive and guideline for future practice rights and his scope of practice and services. Diagnosis and treatment centre on the supernatural, including witchcraft. It is not a bio-medical science. Mental impairment is also a strong indicator during supernatural possession “to can and to may” practice as a traditional healer.\(^4,7-9\) This negative mental indicator, coupled with his future rights of practice, especially the unwritten rights, can have serious legal consequences for the healthcare sector and the personal and general healthcare safety of patients.

The present professional incarceration of the traditional health practitioner because of his risky and dangerous practice-services allocated to him by the Traditional Health Practitioners Act No 22, had been anticipated by the eminent and far-sighted academic and psychiatrist/psychologist, Prof Jan Robbertze, when he warned South Africans nearly forty years ago:\(^29\) “We are busy with a re-evaluation, I want, however, to warn that we do not lose perspective in the process. We are scientists and we must uphold our scientific traditions for the interest of our patients and the community. We cannot depend on hearsay information, anecdotes and pseudo-social and psychological speculations. In this respect we must especially guard that we do not give in to political pressure and throw our hands in the air and say: Let we give the mass for what they ask” (p. 1).

**Strength and limitations**

This study focuses on the masked intentions of the Traditional Health Practitioners Act No 22 (2007). The decline in good governing principles and ethics in South Africa has spread to the healthcare sector. This will make the positive impact of the research minimal.
Conclusion

The new unwritten practice rights of the South African traditional health practitioner are well masked and very comprehensive. The impact of these rights can be much more devastating than the written rights professed and described by the legal definition traditional philosophy embedded in the Traditional Health Practitioners Act No 22 (2007). It empowers the traditional health practitioner with many new practice rights that can infringe on the practice domains of the pharmacist, nurse, medical doctor, psychiatrist, psychologist, chiropractor, homeopath, phytotherapist, naturopath and osteopath. It also has the potential for serious medical misconduct, even criminal behaviour, by the traditional health practitioner.

In light of the present official campaign to activate the Traditional Health Practitioners Act No 22 (2007), the traditional health practitioner surely will soon be fully active in terms of his new practice rights, written as unwritten, offering comprehensive practice services. People may take up these new practice rights gradually, or changes can come fast, depending on the future political climate of South Africa. This outcome spells disaster for the established healthcare practitioners, healthcare sector and especially the patients using public healthcare services.

The eagle has landed in South Africa in 2007, loud and clear. This country’s health establishment must take note of it.

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DECLARATION OF LANGUAGE EDITING

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DECLARATION OF LANGUAGE EDITING

I, Christina Maria Etrecia Terblanche, hereby declare that I edited the research study with the title:

A political-historical literature review of the statutory impact of the Traditional Health Practitioners Act (22 of 2007) and the traditional health practitioner on the empowerment of the present and future South African healthcare establishment

for Gabriel Louw for the purpose of submission as a research study for examination. Changes were suggested in track changes and implementation was left up to the author.

Regards,

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