

PREVENTING AND TREATING HIV & AIDS: IN SEARCH OF CONSTRUCTIVE COOPERATION BETWEEN CONVENTIONAL AND TRADITIONAL HEALTH PRACTITIONERS

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Seventy thousand babies infected with HIV are born to South African families every year, and 300,000 South Africans die of AIDS each year. In South Africa alone, 12 percent of the population, about 5.7 million, are infected. Professor of medicine Bruce Walker has worked on behalf of Harvard University's team that oversees vaccinations research in Durban, South Africa since 2002. With the number of infected and dying HIV& AIDS patients and the number of children born infected Walker laments, "There's no way we are going to be able to treat our way out of this epidemic." Walker speaks for orthodox medical practitioners in virtually every country in sub-Saharan Africa.

Orthodox Physician Short-Fall

The World Health Organization surveyed the number of health workers in Africa and projected the need for orthodox medical practitioners to 2015 and their conclusions echo Walker's on-the-ground observation. Africa's demands and requirements for health workers (doctors, nurses, community health workers, etc) are expected to fall short by 167,000 by 2015. The shortages are a function of the number of people seeking to enter health fields and the amount of money necessary to support a health system that will attract health workers. While globally there will be more than enough health workers, the World Health Organization projects Africa to suffer the greatest from shortages due to the disproportionate level of disease on the continent and distributional problems—some practitioners simply don't want to work in the difficult environment that African communities offer.

African countries with concentrated concerns for the training and retention of health practitioners include Ghana, Uganda, South Africa and Nigeria, but virtually none of these countries are able to prevent out-migration of physicians.

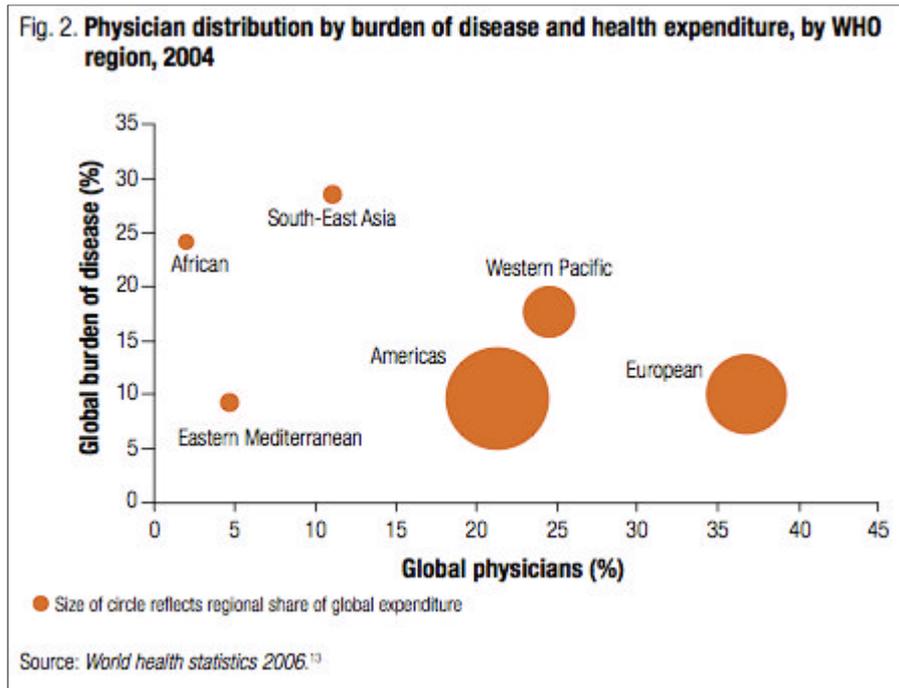
Figure 1: Ratios of physicians to population in Selected African Countries

Ghana has a life expectancy at birth of 57 years and according to the WHO has lost about 30% of its medical practitioners to out-migration. Ghana currently maintains about 1 physician for every 6700 people living in the country. This is quite an achievement when compared with Chad (one for 20,000), Burundi (one for 34,744) and Tanzania (one for 10,000). Mozambique has 548 physicians serving a population of 22 million people.

Chronic diseases, diarrhea from Cholera and other sources, malaria, and HIV& AIDS combine to challenge the most committed physician.

In the face of these conditions, we hear Dr. Walker's lament very clearly.

Africa's countries have the lowest ratio of orthodox physicians to population need only second to Asia based on the "burden of disease" and gross expenditures. (See Figure 2) Africa's shortage of physicians, far outstrips Asia.



More than 60% of Africa's populations (and in some countries like Ghana 80% of the population at some point in a year) use and rely on traditional healers and the medicines they formulate based in traditional knowledge rooted deep in the land and peoples. In South Africa's Venda area, for example there is one traditional practitioner for every 700 – 1,200 people. In Swaziland traditional healers number one for every 110 people—equal to the ratio in Benin City, Nigeria. Even in Kenya's urban centers there is a traditional healer for 833 people. These figures are repeated all over Africa just as ratios of orthodox health care workers are one to 10,000 and 40,000. Clearly, traditional medicine practitioners are central to the health systems of Africa and it is orthodox medicine that is on the periphery. Despite the marginal position of orthodox medicine, it remains the primary point of emphasis by the World Health Organization and majors sources of funding and policy support.

Indeed, the ratio of traditional healers to served populations in Africa's sub-Saharan states is highly favorable.

Indeed, Ghana may have the foundational approach to responding to health worker shortages and the complex of disease including HIV&AIDS. When Ghana achieved independence under the leadership of Dr. Kwame Nkrumah the new state made laws recognizing traditional medicine and healing systems as an integral part of the country's health system. Okomfohemaa Nana Akua Oparebeah received Dr Nkrumah's support to form an umbrella organization for Traditional Healers known as the *Ghana Psychic and Traditional Healing Association*. The association set standards that respect local healing practices and guidelines for the certification of traditional healers. The Center for Scientific Research into Plant Medicine at Akuapim Mampong, Ghana was also established with the responsibility for conducting research into the use and identification of plants used in traditional medicine. *Kwame Nkrumah University of Science and Technology* (KNUST) offers an Herbal Medicine degree.

Under a law enacted the *Traditional Medicine Practice Act 595* of 2008, the government of Ghana defined "traditional medicine" in this way: "'practice based on beliefs and ideas recognized by the community to provide health care by using herbs and other naturally occurring substances" and herbal medicines as "any finished labeled [sic] medicinal products that contain as active ingredients aerial or underground parts of plants or other plant materials or the combination of them whether in crude state or plant preparation". By so doing, the government set in place a council and certification process that rivals virtually all orthodox medical systems.

As a result of official endorsement and sanctions by the State, Ghana's traditional health and traditional knowledge systems combine to form a major part of the health system.

The World Health Organization defines traditional medicine as; "'health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being." In Ghana as in virtually all other countries in Africa, traditional health care is a holistic one that integrates the people's ethics, religious, moral and cultural values.

Under a World Bank and World Health Organization initiative, guidelines for traditional medicine and genetic resource benefit sharing were being when? formulated with these points emphasized:

1. To ensure access, sustainable livelihoods, and equitable sharing of benefits from traditional knowledge related to plant genetic resources.
2. To facilitate rights protection of individuals, communities and the nation, through a suitable legal and administrative framework, for the use of traditional knowledge and the related plant genetic resources.
3. To foster research and development, innovations and capacity building, for the optimal and sustainable use of traditional knowledge and plant genetic resources.
4. To promote public awareness and facilitate advocacy for the development of traditional knowledge and the sustainable use and conservation of plant genetic resources.

(Global Environmental Facility of the World Bank with contributions by WHO-AFRO)

Given the time honored use of traditional medicines that predate orthodox medicine (conventional medical systems have less than 150 years of practice) one would think that traditional medicine would have wide institutional support in the World Health Organization and orthodox medical practices throughout Africa.

One would imagine, given Dr. Walkers lament, traditional medicine integrated into the existing orthodox health systems would be virtually automatic. By the numbers, traditional healers have the confidence of the populations, access to the populations, commitment to the populations and access to plant, animal and spiritual medicines proven to be beneficial. At the same time orthodox medical practitioners have techniques and medicines that benefit people infected, for example, by malaria and HIV&AIDS. One would imagine that a constructive relationship between traditional medical systems and orthodox medical systems would not only be possible, but mutual beneficial and ultimately beneficial to a huge population in need.

An integrated system would allow for orthodox practitioners and traditional practitioners to initiate referrals of patients, share knowledge, and engage in cooperative practices to emphasize HIV & AIDS prevention as well as treatment. Sustained access to the population is essential to achieve prevention. Traditional healers have access and orthodox physicians do not.

Of course, there are some draw-backs that undermine the possibility of wide-spread traditional medicine/orthodox medicine integration and collaboration.

“I won’t deal with that person, he is a quack!” says the orthodox medical practitioner. “I won’t deal with that person, he is a quack!” says the traditional healer. Such is the gap between orthodox physicians who practice medicine in offices and clinics and the traditional healer who practices healing arts in the bush and people’s homes.

Orthodox medicine is very expensive, and much too expensive to be sustainably offered in Africa’s countries where the economic base is limited. Orthodox medical practitioners are located mainly in urban settings and rarely have access to rural settings.

The United States government initiated in 2004 the President’s Emergency Plan for AIDS Relief (PEPFAR)—initially offering \$15 billion for the first five years and subsequently increasing that allocation of spending to \$48 billion to 2013. Unfortunately, the Barack Obama administration decided to level off the spending for PEPFAR and refocus efforts on maternal and child health. The Clinton Foundation and Soros Foundation both have significant funds in support of HIV&AIDS treatments, but the problem dwarfs the funding. Given the reductions or limitations in funding the modest efforts of limited numbers of physicians have turned to raising \$15 and \$50 donations—much the same effort as was going on in 2003 before the \$15 billion commitment of 2004. Sustained effort is now declining.

Traditional Healer/Orthodox Physician referrals—low cost solution

These obstacles seem quite imposing, but the least of them is the “he’s a quack” argument. Getting traditional healers and orthodox physicians to work with one another and refer to each other in the prevention and treatment of HIV&AIDS as well as malaria and diarrheal- related diseases is a far more cost effective approach to getting prevention support and treatment to the suffering populations. Getting orthodox physicians and traditional healers to support each other’s approach to delivering health is essential to serving the needs and demands of Africa’s ailing populations.

We at the Center for World Indigenous Studies have undertaken strong efforts over the last five years to promote methods and practices that have minimal cost that can enhance the delivery of health and healing support to stressed communities in Africa, Asia and the Americas through constructive engagement between those who deliver health services. Our approach has been to promote structured referral agreements between orthodox medical practitioners and traditional healers that encourage and help facilitate partnerships in health delivery.

One major vehicle for promoting health practitioner partnership agreements has been through the biennial meetings of the Global Summit on HIV/AIDS, Traditional Medicine and Indigenous Knowledge. The Center for World Indigenous Studies has worked with Africa First, LLC headed by J. William Danguah and his organizing efforts to draw together support from the Health Ministry of Ghana, the United Nations, United Nations AIDS and Esperanza Medicines Foundation to convene four international sessions: one session in Saint Paul Minnesota, USA and three at different venues in Ghana.

During the 3rd Global Summit held in Accra, Ghana a combination of traditional healers and orthodox practitioners were delegated by the conference to sit with each other for several days and negotiate a set of principles that would help build bridges between them. Simply laying the foundation for an agreement to collaborate with each other on referrals became a central focus of the negotiators. After intense debate and negotiations the traditionalists and orthodox health givers announced their agreement. The Conference announced a declaration on 18 March 2006 reporting the concluding decision listing a key objective that participants would promote:

1. To serve as a forum for the identification and testing of potentially beneficial low-cost naturally derived medicinal products;
2. **To promote partnerships between indigenous healers, conventional medical practitioners** and corporate institutions for sharing their indigenous knowledge of plants of medicinal value for future development and production of drugs and herbal products; and
3. To encourage governments to adopt and enforce laws to protect and conserve plants of medicinal value; and to protect the rights of indigenous practitioners.

The negotiated agreement came together in Ghana, the place where Dr. Nkrumah set in motion the integrative process between traditional and orthodox health systems.

These conferences are now focused in part on promoting states' government legislation in various countries to encourage traditional medicines/orthodox medicine integration and referrals. Overcoming "the quack" argument is the greatest obstacle at the moment to promoting a low cost solution to prevention and treatment of HIV&AIDS and other serious diseases in Africa. The declaration calling for "partnerships" in the Global Summit is a realistic and most realistic approach to immediately expanding the global health system at a low cost—the systems are already in place.

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