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Governing the Traditional Health Care Sector in Kenya: Strategies and Setbacks

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Introduction

In Kenya, social, cultural and historical factors have led to the emergence of a plural health care system in which traditional and contemporary western medicine co-exist. The colonialists and even some westernised Africans initially regarded African traditional medicine as magic. Mission doctors described traditional health practitioners as witches and dismissed their practices as unscientific and irrational (Beck 1971, Sindiga 1995, Tinga 1998). The colonial administration outlawed witchcraft practices under which many traditional health practices were subsumed. Consequently, the colonial administration undermined traditional health practices by arraigning suspected witches in courts (Tinga 1998). These attitudes fuelled the belief that the traditional health care sector was full of fake, 'snake-oil' practitioners bent on capitalising on 'ignorant' patients and on the alleged shortcomings of modern health care.

The official recognition of traditional medicine in Kenya originated from the WHO's Alma Ata declaration of 1978 (WHO and UNICEF 1978). Since then, traditional medicine has gradually carved itself a niche in the provision of health care services in Kenya. However, this emerging sector faces a myriad of problems, of which governance features prominently.

By governance, I mean stewardship, management, leadership and guidance, which can be operationalised into organisation, supervision and control. These terms are used together in an attempt to more accurately convey the complex meaning of governance. Governance also engenders accountability and responsibility. For example, the weakening of modern health care systems in Kenya is reflected in the falling health status of the population. Over the years, the burden of disease has increased, leading to a decline in life expectancy (KDHS 1998, 2003). The decline in life expectancy is a clear indication of the modern health

care system's failure or at least inability to cope with growing health care demands (KDHS 2003). This is partly due to the weakening of health system structures and governance.

It is in the context of the increasing importance of traditional medicine and the failing health care systems as indicated by the falling health standards in Kenya that the issue of governance of indigenous medicine is considered. This paper, therefore, examines governance of indigenous health care resources in Kenya with specific attention to strategies of managing and the setbacks involved.

The Quest for Governance of the Traditional Medical Sector

In Kenya, both modern and traditional medicines co-exist as parallel systems but with little coordination between them (Owour 1999). Previous efforts to coordinate the activities of traditional and modern health practitioners in Kenya have not been successful due to mutual mistrust and suspicion between ethno-medical and biomedical practitioners. In 1989 for instance, a task force committee with the objective of linking the activities of traditional health practitioners, modern doctors, scholars and researchers was launched in Nairobi but hardly took off (Kimani 1981, 1995). This effort did not take into account forms of organisation of traditional health care activities and associated operational activities.

The health provision strategies have for a long time not taken into account what the patients think about their health and where they go for treatment. As a result, there has been a mismatch between the kind of health services provided and what people actually opt for in the event of illness.

In order to make health care provision policies responsive and sensitive to the consumer (patient) preferences there is a need to understand the dynamics of the utilisation of traditional health care services. Recent research findings (Nyamwaya 1992, Ngetich 2004) indicate that there exists interaction between traditional and modern health practitioners as well as their patients in terms of cross-referrals of patients. Yet, there is no protocol governing referrals of patients between traditional and modern health practitioners.

Thus, the quest for governance of indigenous health care systems raises a number of critical issues that need to be resolved. These include: intellectual property rights and patents claims, standards of traditional medical practices and care, legal, regulatory and control issues in the traditional medicine sector, as well as organisational frameworks of traditional medical practice and utilisation.

In the light of the above, the following key questions will be addressed:

- First, what are the problems of governance facing African traditional health care sector in Kenya?
- Second, what are the strategies of governance of traditional medicine in Kenya?
- Third, what are the shortcomings or limitations of governance strategies adopted in relation to traditional medical care?

African Traditional Medicine: From 'Magic' to Medicine

A study of the utilisation of traditional medicine falls within the realm of ethno-medical research, a component of health systems research. Health System Research is 'applied research, aiming at improving the quality of health care and optimising the use of available resources in order to meet health needs in a population' (Good 1987, Nuyens 1988). According to Good (1987:17) ethno-medical systems comprise 'all the resources and responses available to a community in addressing its health problems, organised partially and changing over time'. Ethno-medical analysis therefore, focuses on the actual experiences of people and examines how they are perceived, labelled, communicated and managed in interactions with family, social network and therapists (Good 1987).

Academic research on traditional medicine and health care systems in Africa can be traced back to the works of British colonial ethnographers (Rivers 1924, Evans-Pritchard 1937). Though not particularly focussing on African medicine, these studies provided for the first time detailed descriptions of medical practices of various African peoples. However, due to the structuralist approach which was then dominant in Britain, these studies gave attention to healing only with reference to magic and rituals. The overall impact of this approach was a reduction in the study of health and illness 'to studies of witchcraft, magic and in general curative or socially re-adjustive ritual practices, with herbalists and empirical rational diagnoses, treatment and prophylaxis as residual categories' (Foster 1976: xiv-vx). As Yoder observes, 'the study of medical belief and practices became subsumed under the rubric of magic, witchcraft and religion' (1982:4).

The above works shaped subsequent in-depth studies that focussed on medical knowledge and practices of different peoples in Africa. Works along this line were done among the Batabwa and Bakongo of Congo, the Bono of Ghana, the Zulu of South Africa and the Amhara of Ethiopia (Janzen 1978, Roberts 1979, Warren 1974, Young 1975). However, these studies tended to focus almost exclusively on ethnographic descriptions of African traditional medical practices of particular ethnic groups.

In an international conference held in Alma Ata, Russia, WHO called for the use of indigenous health resources in primary health care (WHO and UNICEF 1978). This declaration inspired many researchers, who sought to determine the actual and potential role or contribution of traditional medicine in national health care (Pilsbury 1982, Young 1983) as well as identify potential areas of cooperation, conflict and integration between modern and traditional medicine (Unschuld 1976, Pearce 1982, Green and Makhubu 1984). These studies found that traditional medicine was a highly valued medical resource in many third world countries that could be promoted and tapped for primary health care.

After the recognition of the actual and potential value of traditional medicine in primary health care, attention in policy and research shifted to how to integrate traditional medicine in modern health care (Pearce 1982, Rappaport and Rappaport

1981). But efforts to integrate traditional medicine in modern health care became limited to the incorporation of traditional healers, particularly Traditional Birth Attendants (TBAs), in the national health care system. This was mainly because TBAs were viewed as being closest to biomedicine. Nonetheless, traditional medicine maintained its identity and vigour resulting in the parallel co-existence of traditional and modern health care systems.

One way of promoting traditional health care in Africa was through professionalisation. Twumasi (1984), Last (1986) and Chivundika (1994) identified areas of increased professionalisation among traditional health practitioners in Africa. These developments have seen traditional medicine achieve some measure of organisation and recognition, which is an important step towards increased governance of traditional medicine.

Governing the Traditional Health Care Sector in Kenya

It is now widely acknowledged that about eighty percent of the world's population rely on traditional medicine for primary health care (WHO 1985). Yet more than eighty percent of state resources in Kenya are allocated to modern health care delivery (Republic of Kenya 1996). This clearly demonstrates that there is a discrepancy between what the government offers in terms of health care and what the people actually accept in the event of illness occurrence. Although this scenario may be partly rooted in problems of access, there is increasing evidence that even where modern medicine is fully accessible, the people still resort to traditional medicine (Ngetich 2004).

What this suggests is that there is a need for the government to provide stewardship in the traditional health care sector with a view to harnessing indigenous health care resources by shaping and guiding its development. Thus, in the quest for a health care system that is responsive to the people's health needs and a system of health administration that is responsive to the health care practitioners and health services users, the issue of governance of the traditional health care sector needs to be addressed.

Strategies

It is evident, at least from government policy documents such as annual development plans and seasonal papers, that the Kenyan government recognises the importance of traditional medicine. But the concern is, what has it done to improve or promote this sector in the pursuit of the Millennium Development Goals for health?

First, what is needed is licensing and registration. The government, at local government level i.e., municipalities and councils, as well as at national level (ministerial), registers and licenses traditional health practitioners. This is done through the Ministry of Gender, Sports, Culture and Social Services (Department of Culture). Within the Ministry, the Department of Culture is responsible for

registering the traditional health practitioners. The traditional health practitioners must also register their clinics with their local authorities as business enterprises. Through registration and licensing, the government exercises some rudimentary sense of control on the traditional medical practice.

Second, the formation of traditional healers associations is desirable. The Kenya Association of Herbalists (KAH) which has branches throughout the country, provides the individual herbal practitioners with a means to organise themselves and agitate for their interests. With swelling membership this organisation has increasingly gained some political clout and comments on issues affecting its members in various forums such as workshops, seminars and even newspapers. The KAH has increasingly moulded itself into an advocacy group seeking to promote the 'profession' and guard 'professional interests'. However, active members tend to be drawn mainly from urban areas. The bulk of rural traditional health practitioners remain relatively unorganised as they operate individually.

Third, training. The government has occasionally organised training sessions (usually seminars and workshops) for traditional health practitioners where it disseminates information on specific health issues such as the anti-HIV/AIDS campaigns. In most cases, the traditional health practitioners do not just passively receive information from the government but occasionally take the opportunity to express their concern in the training sessions.

Setbacks

Traditional medicine as a viable healthcare option faces a number of setbacks in Kenya. These setbacks, which range from policy, legal issues to attitudes, are outlined below.

First, the administrative separation of traditional and modern medicine. Traditional medicine is placed in the Department of Culture in the Ministry of Culture, Social Services, Gender and Sport, while modern medicine is placed in the Ministry of Health. This remains a major obstacle to cooperation between the two sectors, and consequently prevents the development of a coordinated and integrated health care system. What is going on between the two unrelated ministries is difficult to harmonise. This has led to major discrepancies in health policy formulation relating to the traditional health care sector. The fact that the personnel in the Ministry of Health are mainly diehard biomedics bent on seeing traditional medicine through a biomedical lens while those in the Ministry of Culture view traditional medicine through a cultural lens makes the harmonisation of issues concerning traditional medicine difficult. While traditional medicine is valued in the Ministry of Culture mainly as a cultural heritage, the Ministry of Health may want to see it from a purely medical aspect. Finding a meeting point for these two perspectives on the traditional medical sector and the formulation of appropriate health policy is primarily a governance challenge in the health care system.

Second, there is an aura of mystery and secrecy surrounding traditional health care. Also, secrecy may be understandable as a way in which traditional health practitioners guard their valuable health care knowledge on which their families depend. It has contributed to modern health practitioners finding it difficult to accept traditional medicine. As a result, many modern health practitioners have difficulties accepting religious, magical or cultural beliefs often associated with traditional medical practice. The modern health practitioners perceive these beliefs to be contrary to sound medical science, and for some, their Christian religious conscience. Thus, the association of traditional medical practice and traditional medicine in general with witchcraft and sorcery as well as the continued marginalisation of the entire sector constitutes a major setback to the utilisation of traditional medicine in Kenya.

Third, there is the lack of evidence. In spite of the acknowledgement of the continued utilisation of traditional medicine, its effectiveness in the management of various health problems is not documented. As such, the utilisation of traditional medicine continues to depend on undocumented testimonies of patients often spread through social networks.

Fourth, there is the low level of education. Most traditional health practitioners have a low level of formal education. They received their training through informal means and apprenticeship. As such, most of their knowledge is not documented, nor their practices. This poor educational level has led to poor record keeping. Furthermore, most of them have no or little formal training in basic health issues.

Fifth, the government has failed in its regulatory role. This is evidenced by the lack of adequate supervision and control of the activities of the traditional health practitioners. This has resulted in the sector being entered by quacks. This is particularly in urban areas where these healers enjoy anonymity. In this context, the clients are forced to depend on self-made claims, which may have little practical backing. Some give imagined testimonies of people whom they had previously successfully healed. This issue adds to our concern for quality care even in the context of traditional medicine. In the serious matters of health, traditional health practitioners should not be allowed to operate freely. The Association of Herbalists, which would act as a regulatory body, has no legal powers to enforce discipline among its members. As such errant members get away with malpractices.

Conclusion

The traditional health system and traditional practitioners continue to operate freely and with little control and supervision from the state. Such free operation makes traditional medical practice open to abuse by quacks bent on cashing in on the desperate patients. It is therefore clear that the state and the government in particular has failed to provide stewardship to the traditional health care sector. This has resulted in poor quality of services in the sector. Nevertheless, this paper concludes that although the traditional health care sector is peripheral in overall

health care in Kenya, it is emerging as a significant alternative that requires proper governance approaches.

Policy Recommendations

The following policy recommendations are intended to improve the governance of indigenous health care systems.

Legal and Regulatory Framework

The fact that many people still use traditional medicine alongside modern medicine demonstrates the need for the promotion of traditional health care. Furthermore, as a way of reducing apprehension among traditional health practitioners that they will lose their standing, there is a need to legalise their medical knowledge and discoveries through patenting. This will encourage traditional health practitioners to share their often secretive medical knowledge for the benefit of many in the society. It is therefore necessary to incorporate and implement policies and legislation governing intellectual property rights and the sharing of rewards derived from traditional medicine. Hence, a legal framework for professional health care practice among traditional health practitioners needs to be put in place as a mechanism to guard against malpractices and enhance fair play.

Quality and Safety Control

Traditional healers need to be trained in the processing and storage of medicines to minimise the dangers to which patients are exposed through the use of traditional medicine. Quality control mechanisms would ensure the safety of the medicines. This can be attained through the acquisition of appropriate drug processing and storage facilities, which few traditional health practitioners currently enjoy.

Governance Structures

In order to promote the governance of traditional medicine there is a need for some organisational and structural changes. One problem is that traditional medicine at present falls under the Ministry of Gender, Sports, Culture and Social Services (Department of Culture), while all other aspects of health care are under the Ministry of Health. For better management of health care provision, there is a need to bring all health issues, including traditional health care, under the Ministry of Health. In addition, the finance mechanisms disadvantage traditional health practitioners in that various health care financing schemes (whether private or public) such as private health insurance and National Health Insurance Funds do not cover health services provided by traditional health practitioners. There is a need for employers to consider including traditional health practitioners in their medical schemes. This would enable their employees to obtain support from their employers or health insurance for medical costs incurred for treatments by traditional health practitioners.

The Need for Cooperation

Governance strategies should aim at promoting cooperation between traditional and modern health practitioners. Since patients consult traditional and modern health practitioners, there is a need for the practitioners of both forms of health care to cooperate for the benefit of patients and the improvement of health care in general. Such cooperation can take the form of cross referral of patients, exchange of information on illnesses, and techniques of investigation. The cross referral of patients that already exists (though on a small scale) is a step in this direction.

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