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Review Article

Integrating Phytomedicine in the Complementary Management of High Blood Pressure (BP) at The Primary Health Care Level in Africa: A Commentary

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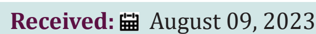

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Abstract

High blood pressure one billion people and is the common risk factor for death throughout the world. High blood pressure causes hypertension, which is a major risk factor and one of the leading causes of cardiovascular disease (CVD) such as Acute Myocardial Infarction (AMI), stroke, heart failure and death [1]. Patients make catastrophic out-of-pocket payments to manage this condition. Patients still visit traditional healers even after consulting with medical personnel and are apparently willing to pay out of pocket for herbal medicines. Since there is no disclosure of their hidden consultation with herbalist to health personnel; the risk of incurring adverse drug-herb interactions is perceived problematic. There is the lack of legal framework and official recognition clinical cooperation by conventional medicine practitioners and herbal medicine practitioners. In most African countries such as Cameroon where this study is undertaken, there are no laws guiding the traditional medicine practitioners (TM). The TM sector is poorly organized with poor clinical audits with anyone can enter the trade and safety of practice questionable. There are also competitions in the trade between medics and trade-practitioners for patient due to lack of proper integration of traditional medicine in health care systems. Traditional healers are not involved in the running of services in charge of their work in the ministry of health, are not attached to top research centres, and are rarely given the opportunity to consult in health care institutions as in other countries in Africa.

a) The Government should establish the necessary institutional and financial support to promote the potential role of herbal medicine in primary health care delivery.

b) Traditional medicine should be officially legalised and made part of the official health care system in Cameroon.

c) There should be an improvement in the collaboration between Medics and Tardi-Practitioners

d) Government should openly and effectively support scientific research into traditional medicine therapies.

e) Patients should be provided with adequate information on both systems of health care.

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Introduction

Problem Based Context: a Background Synthesis.

High blood pressure affecting one billion people and is the commonest risk factor for death throughout the world. Hypertension is a major risk factor and one of the leading causes of cardiovascular disease (CVD) such as Acute Myocardial Infarction (AMI), stroke, heart failure and death [1]. World over hypertension is responsible for 51% of cerebrovascular disease and 45% of ischemic heart disease deaths. World health statistics [2]. estimated the prevalence of hypertension to be 29.2% among males and 24.8% among females. Approximately 90 percent of men and women who are non-hypertensive at 55 or 65 years will develop hypertension by the age of 80–85. Hypertension used to be regarded as a disease of affluence, but this has changed over the years with increasing prevalence among poor sections of society. The economic burden of CVD in Africa is significant [3]. In line with this, Stewart and Sliwa [4] opine that CVDs will cost the continent billions of dollars in the next decade. Hypertension could be ranked as one of the major causes of significant financial burden, including the cost of caring for all the complications arising from it like stroke, ischemic heart disease and congestive heart failure [5]. The financial burden comes in the form of direct healthcare costs related to treatment of CVD and its risk factors. These costs are borne by the individuals, governments, and the private sector [6].

Furthermore, there are numerous indirect costs related to hypertension. These costs include the loss in productivity of workers struck by stroke, heart failure, and ischemic heart disease [3]. Other costs include the lost savings and assets that are foregone when families must meet catastrophic healthcare expenditures such as those associated with rehabilitation following stroke or dialysis following renal failure. In spite of the current relatively low prevalence of hypertension in some countries, the total number of people with hypertension in LMICs could be high and a cost analysis of possible anti-hypertensive drug treatment indicates that LMICs cannot afford the same treatment as in high income countries. The use of alternative therapies is becoming more popular in the recent times especially due to the increasing cost, distrust and limitations of modern western medical care. There is a universal trend towards nature-based herbal medicine is now being modernized and being accepted by people who would not have used them. People use alternative therapies for preventive and curative purposes [7].

Generic Root Causes for Policy Consideration

There is a galloping rise in the incidence of high blood pressure in Africa and is reported in Cameroon [8]. This is caused by changing lifestyles which include poor eating habits leading to excessive weight gain, sedentary lifestyles leading to little or no physical activity, excessive salt intake, increase alcohol intake and smoking, and no frequent hospital visits for constant health checks [9]. It constitutes a considerable economic burden, as patients are required to make catastrophic payments to effectively manage this condition. In the face of competing health priorities, some patients are unable to meet up with management costs. This is because chronic disease management costs are mainly out-of-pocket, as there are no insurance schemes to cover these costs [5,6]. Phyto medicine, on the other hand, could be a suitable substitute due to its apparent popularity and the willingness of people to pay out-of-pocket for its services, as well as its adverse effect on patients' compliance to orthodox antihypertensive therapy [3,4]. Despite the obscurity regarding the efficacy of traditional medicine in the treatment of hypertension, patients still visit traditional healers even after consulting with orthodox medical practitioners. This is because traditional medicine is less costly, has little or no side effects, has more cultural acceptability, and patients go for it since it seems to work well for others.

A Comment for Policy Consideration

The Beijing Declaration, published by the WHO [5] calls for a partnership between modern and traditional herbal medicine to help bridge the equity gap in public health and highlights the importance of research to support the development of traditional herbal medicine in delivering appropriate, safe and effective treatments. In addition, achieving universal health coverage (UHC)-that is aimed at ensuring that all people have access to promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that they do not suffer financial hardship when paying for these services- has been set as one of the overarching goals in the World Health Organisation's 12th General Programme of Work for 2014 to 2019 [2].

Critique Of Health Policy: A Case Reflection of Cameroon

The health system in Cameroon is organised in three levels, represented in the form of pyramid. At the summit is the Central level, the intermediate and the operational level at the base. Three types of structures are integrated into each level namely: the administrative and finance healthcare and community participation (dialogue structure). The Central Level: The administrative and management structures are represented by the minister of Public Health. The health care structures consist of the three general and reference hospitals, a university teaching hospital and four assimilated central hospitals. The Intermediate Level: The administrative and management levels consist of the ten regional delegations of public health. The health care structures consist of nine regional hospitals and affiliate structures and the communication structures are made of the regional management commission or regional funds [10].

a. The Operational Level: The administrative structures and management structures consist of 173 District health services. The existing structures have 154 district public hospitals, 87 private hospitals, 148 divisional health centre, 1700 health centres and 620 private health centres.

The Traditional Medicine Sub-Sectors: Currently Cameroon has at all levels, a non-structured or poorly organized organigramme of traditional medicine [10]. The conference of Regional Governors organized in 1976, by the Ministry of Public Health for putting an

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Organizational structure to valorise traditional medicine permitted the establishment of three organs in Operation such as:

a. The National Commission for Traditional Medicine, in charge of helping the government in the definition and exploitation of traditional medicine.

b. Permanent committee of Traditional Medicine in charge of coordinating the research activities and practice of traditional medicine.

c. The Medical Institute for the study of medicinal plants in charge of operational research. The Political engagement was validated by the ministerial decision No 031/D/MSP/DS/BT of 31 July 1979 creating and organizing the Traditional Medicine sector within the jurisdiction of the Ministry of Public Health [10].

The decree of 4th December 1979 organizing the General Delegation for technical and scientific research (DGRST) formerly known as National Office of Technical and Scientific Research (ONAREST)-IMPM was created in 1974. IMPM was charged with the responsibility of drawing up a realizable research programme on TM to improve on the health conditions of Cameroonians. The IMPM Institute have four centres of which the Centre for the study of medicinal plants (CEPM) was aimed at elaborating a research programme geared towards the production of drugs and adequate therapeutics using local natural substances. The creation of a traditional medicine unit at the Central Hospitals of Yaoundé, took place in 1981. The organization of the organigramme of the Ministry of Public Health integrating a service for community health and TM under the tutelage of Preventive and Rural medicine happened in 1989. The launching of the first seminar/workshop on TM and Cameroonian pharmacopoeia in the medical school (CUSS), Yaoundé took place from the 10–14th July 1989.

The creation of association of TM enacted by the freedom of association law No 90/053 of 19 December 1990 was followed by a circular note No: D26/NC/MSP/SG/DMPR/DAMPR/SDMR/SS-CMT of 16th September 1991 authorizing conventional medicine to collaborate closely where possible with trad practitioners. The decree No. 93/215 of 4 August 1993 authorized the reorganization of IMPM and changing the name from. CEPM to CRPMT (Centre de Recherche en Plantes Médicinales et en Médicines Traditionnelles). Then came the prime ministerial decree No 98/405 PM, fixing the homologation strategy to put in the market pharmaceutical products. This led to the creation of the National Drug Commission, which harbours the Commission specialized in Pharmacovigilance and traditional pharmacopoeia; secondly the Commission specialized in Phytotherapy and alternative therapeutic techniques. The presidential decree no 2002/209 of August 2002 organizing the Ministry of Health, put in place a sub-directory in charge of Primary Health, the service of traditional social-health care, made of the office of Ethics and Social Health care deontology, and the bureau of Welfare and Legislation Control. This decree also created a division of Operational Research made up of Scientific Network Cells in charge of support in medicinal plant research [10]. Local initiatives are in progress by different non-governmental organisations and the state Institutions to train trade-practitioners the basic conservation techniques and preparation of their herbs within the framework of quality assurance.

Constraints Of Herbal Practitioners Requiring a Policy Direction

One of the main problems that have caused a slow collaboration between medics and trade practitioners is the lack of legal framework and official recognition of traditional medicine by conventional medicine. Trad practitioners are not accepted but tolerated because of the decree that has created a harmonization of the primary health care involving all stake holders. There are no laws guiding the TM practice in Cameroon. The TM sector is volatile and isolated and uncensored, and anyone can enter the trade, and this has consequently led to breeding quacks or what is known as "charlatans". There are also competitions in the trade between medics and trad practitioners for patients. The party with provisions of the best incentive gets the patients. There is a lack of proper integration of traditional medicine in health care systems. Traditional healers are not attached to bodies like the malaria or HIV/AIDS control committees, they are not involved in the running of services in charge of their work in the ministry of health, are not attached to top research centres, and are rarely given the opportunity to consult in health care institutions as in other countries in Africa.

Recommendations For Policy Framework

The Governments should establish the necessary institutional and financial support to promote the potential role of herbal medicine in primary health care delivery. Priority should be given to the development of herbal medicine by means of the following measures:

a) inventorying and documenting the various medicinal plants and herbs which are used to treat common diseases in each region of Cameroon.

b) establishing local botanical gardens for the preservation of essential medicinal herbal plants in different parts of each country, to ensure a sustainable supply of safe, effective and affordable medicinal herbs.

c) setting up testing laboratories with adequate facilities for the assessment of the efficacy of medicinal herbs and establishing dosage norms for the proper administration.

Traditional medicine should be officially legalized and made part of the official health care system in Cameroon. Intellectual property rights protection should be extended to traditional medicine because some of them have treasured products they have worked with over generation and need to be supported for protection rights.

The organization of traditional medicine practice via a policy guide will bring about a controlled practice and a more responsible and harmonized team of trad -practitioners. An integration

framework into the national health sector will bring about putting in place at the disposal of the public standardized traditional medicines, with standard affordable prices as a means of fighting poverty.

Governments in Africa should openly and effectively support scientific research into traditional medicine therapies and integration framework in primary health care sector. A policy framework will generate improvement in the collaboration between medics and trad-practitioners. Patients should be provided with adequate information on both systems of health care. This will empower them for rational decision-making in seeking health care and mitigate the occurrence of adverse drug-herb interactions which can occur when patients take both treatments without the knowledge of the medical personnel [11,12].

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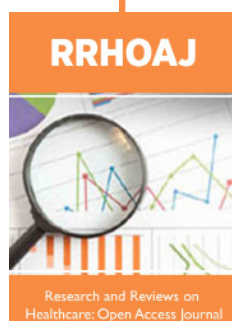

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