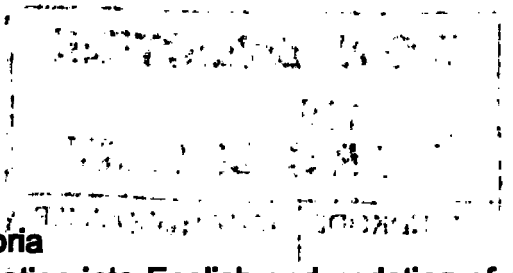
The traditional healer in South African health care

Engela Pretorius
GW de Klerk
HCJ van Rensburg

Co-operative HSRC Programme: Affordable Social Provision

Series editor: ***Ina Snyman*****, HSRC**



HSRC, Pretoria
1991 (Translation into English and updating of references 1993)

The Co-operative HSRC Programme: Affordable Social Provision is centred within the Group: Social Dynamics of the Human Sciences Research Council. The emphasis is on the affordability, effectiveness and general accessibility of social services and provision. In this report the focus is on traditional medicine as a component of health care.

The English version of the report was translated from the Afrikaans original, which was published in 1991. The list of literature references contains several more recent items.

The HSRC, and more particularly the committee of the abovementioned programme, does not necessarily agree with opinions expressed in the report.

ISBN 0 7969 1531 8

Printed and distributed by the HSRC, Pretoria

Available from:

Mrs A. Tucci
Co-operative Research Programme: Affordable Social Provision
HSRC
Private Bag X41
PRETORIA
0001

Tel: (012) 202 2247/2435
Fax: (012) 326 5362/202 2149

EKSERP

Die studie waarop hierdie verslag gebaseer is, is in Mangaung, 'n *township* naby Bloemfontein, onderneem. Die fokus was op respondente se menings oor en gebruik van verskillende kategorieë van tradisionele helers, en op hul sienings van bestaande of potensiële skakeling met moderne medisyne.

Daar is bevind dat 'n aansienlike proporsie van die respondente tradisionele oortuigings ten opsigte van siekte en gesondheidsorg huldig. Baie van hulle raadpleeg tradisionele helers ten spyte van relatiewe jeugdigheid, verwestersing en 'n hoë onderwyspeil, en ten spyte van die betreklik hoë gelde van tradisionele helers.

Die gevolgtrekking was dat ten spyte van vele struikelblokke, tradisionele medisyne onder sekere voorwaardes en sekere omstandighede kan meehelp om die aansienlike leemtes te vul wat daar in die formele, moderne gesondheidsisteem bestaan.

ABSTRACT

The study on which this report is based was undertaken in Mangaung, a township near Bloemfontein. The focus was on respondents' opinions and use of different categories of traditional healers, and on their views about the existing or potential links between traditional and modern medicine.

It was found that a sizable proportion of the respondents maintained traditional convictions with regard to illness and health care. Many consulted traditional healers regardless of the fact that they were young, westernized and well-educated, and that the traditional healers charged relatively high fees.

The conclusion was that in spite of many obstacles, traditional medicine can, under certain conditions and circumstances, help fill the considerable gaps in the formal modern health care system.

CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER 1

CONCEPTUAL AND METHODOLOGICAL JUSTIFICATION

1. RATIONALE OF THE INVESTIGATION

Some years ago the need for a national research programme in respect of **Affordable Social Security** was prioritized by the Human Sciences Research Council (HSRC) and Parliament. One of the subprogrammes, **Affordable Social Provision,** was launched during April 1986 and among the topics earmarked for research were

- informal support systems,
- de-institutionalization,
- self-help groups,
- para-professional and voluntary workers,
- community development.

In September 1987, after consultation with the programme co-ordinator of the above programmes at the erstwhile Institute for Sociological and Demographic Research, the project **Community-based health care: sociological studies in Bloemfontein** was initiated by the Department of Sociology at the University of the Orange Free State as a project of the programme **Affordable Social Provision.** The point of departure of this project is that community health care - being health care by the community for the community - often implies a cheaper, more attainable, more accessible and often a more appropriate and more effective form of health care. In South Africa such community potential or sources of health care too often enjoy accidental or no attention whatsoever, while it in fact has significant value for the affordability of health care. Various reasons can be advanced for this: In the first place there is not enough knowledge in respect of the nature, the range and patterns of supply and utilization of this type of service; secondly, it is opposed and thirdly, emphasis is only too frequently, too heavily placed on professional services which are supply-orientated, rather than need-orientated and with a concomitant lack of involvement by the community itself.

The project in question — on community-based health care — encompasses the most important facets of health care delivery in Bloemfontein and consists of four related subprojects. Traditional medicine is one of these and is the topic of this research report.

2. RESEARCH PROBLEM

Good health and health care are currently accepted in many circles as being basic human rights. Nevertheless, millions of people are still affected by illnesses such as cholera, tuberculosis, malaria and even dietary deficiency diseases. At the other end of the scale

there is a highly sophisticated medical technology which treats the total range of illness up to that very point where the difference between life and death is obscured. This anomaly reaches further and is very succinctly verbalized by Mahler, erstwhile director-general of the World Health Organization (WHO) (Elling 1981: 90-91): "In one sophisticated city more than 70 % of all the so-called health expenditure is used on people who are going to die within the next twelve months ... Countries further down the developmental scale are busy imitating this kind of perversion. In a developing country, which constitutionally declares health a universal human right, you find in one province 80 % of the health budget being used to support one teaching hospital, whereas in outlying parts complete coverage is supposed to be achieved by one general purpose dispensary for half a million people." Besides the maldistribution in respect of modern health care provision, the cost of such care escalates rapidly and serious allegations are frequently heard in connection with the iatrogenic nature and inefficacy of such care.

With regard to the allocation of resources, matters such as defence and security services generally have precedence over health care services, whilst the proportion of the Gross National Product (GNP) of countries which is allocated to the latter, is rarely increased. Third World countries - they constitute more or less two thirds of the world population - with the resources at their disposal cannot cut their health provision according to the expensive Western cloth. Some of these countries are in Africa where a spirit of disillusionment has gradually developed in respect of modern health care models and that as a result of a variety of reasons. Health care resources are mostly found in urban areas where only about one third of the total population lives. These facilities are so expensive that only the affluent inhabitants of the city can utilize them. Only a small portion of the total population therefore has access to facilities to which the greater part of the total health budget is allocated. Meanwhile the orthodox and conventional health care services which have been established for Third World countries are often also culturally unacceptable. The disparity between the high cost of health care and the low yield in terms of improved health is a problem in both developed and developing countries so that the economy of health care systems has become an important issue in various countries.

Gradually a situation has developed where pressure is brought to bear on political leaders, government officials and health officials to provide cheap though effective means of health care provision to all members of a society. It is against this background that there has also been a growing interest from official circles in alternative approaches - among these also manifestations of traditional medicine.

After decades characterized by an uncomfortable, even antagonistic relationship between modern and traditional care systems in Africa, certain changes have, since the late 1970s, taken place. At this moment in time the possible utilization of traditional healers in Western-orientated health care systems enjoys the official approval of the WHO simply because the improvement of the position of all the underprovided populations lies in the full utilization of the available sources - human and material - at the community level.

South Africa is confronted with the same problems in respect of health care provision. What with rising inflation and increased cutbacks in state expenditure on health services, it is becoming impossible to expand official health care provision if such provision is based

on expensively equipped hospitals and health centres. Given these dire circumstances, there is an urgent need for investigating alternative low cost systems. One such alternative which is worthy of investigation is traditional medicine. The utilization of traditional medicine deserves to be considered, not only as a result of the approval of the WHO, but also as a result of the high degree of acceptability of this type of medicine by a great part of the black population in South Africa and as a result of the successful experiments that have been conducted with it elsewhere.

In terms merely of the number of people who world wide are served by traditional health care systems and without considering the shortcomings of such systems, one cannot but deduce that traditional medicine has an important role to play in primary health care. Nevertheless, the South African Medical and Dental Council in 1974 had its rejections of traditional medicine officially embodied in health legislation. It does, however, appear that the *South African Medical Journal*, official mouthpiece of the Medical Association of South Africa opposes the outright rejection of traditional healers. In an editorial in this journal (Editorial 1982:1) it was suggested that medical practitioners should attempt to understand traditional healers' *modus operandi*, accept their activity in certain health care areas, but also help them with the identification of illnesses which can better be treated by modern medicine.

In South Africa, as in various other countries, the debate on the integration or co-operation between traditional and modern medicines still continues. It is especially medical practitioners in the field of mental disease and those who advocate community based health care who make the most urgent appeals in this connection. It, however, still remains a bone of contention within the total South African political, economic, administrative, legal and health situation, and with the different groups which vary in terms of culture, development and state-allotted health resources.

3. PURPOSE OF THE INVESTIGATION

The aims of this investigation were threefold:

(i) to determine and describe the role and utilization of traditional healers in Mangaung, the township near Bloemfontein;

(ii) to argue the possibility/desirability of collaboration between modern and traditional medicine against the background of relevant literature and empirical findings, and

(iii) to consider whether traditional medical systems alone or in co-operation with modern health care systems offer a valuable and exploitable alternative health care option in South Africa.

With regard to the actual situation of traditional medicine, the following matters enjoyed special attention during the investigation:

- determining the manpower situation in the traditional medical sector in Mangaung (the number and types of traditional healers);
- the manner in which help is sought in a pluralistic medical milieu, and

- attitudes in respect of collaboration between modern and traditional medical systems.

4. CONCEPTUAL EXPLICATION

In order to avoid vagueness and ambiguity, a few central concepts will now be discussed in greater detail.

4.1 Medicine, medical system or health system

It would be an understatement to say that there is terminological confusion in respect of the concept health system. Many equivalents or synonyms are found in the literature: Field (1976:568) uses the term **medical system** and describes it as a part of the cultural system of society, consisting of beliefs/convictions, attitudes, role definitions and role specifications, practices and techniques related to health, illness, disability and premature death. Young (1983:1206) uses the concept **medical tradition:** "... a unique combination of ideas, practices, skills, apparatus and materia medica. Another synonym for medical system is the concept **medicine**, as in Western allopathic or traditional medicine. This term can also refer specifically to remedies or medicaments, although confusion rarely occurs, as the meaning is generally clear from the context. In this report **medicine, medical system** and **health system** are used interchangeably in referring to beliefs, practices and social structures relating to health, illness, disability and premature death.

4.2 Modern and traditional medicine

There are various synonyms for modern medicine: **allopathic, Western, scientific, cosmopolitan** or **biomedicine**. All the terms are in general use, even though there are objections to the use of the term "Western", because this type of medicine also has roots in other parts in the world - such as China, the Middle East and North Africa.

So too are there synonyms that are often used for traditional medicine, like **non-scientific, alternative, unorthodox, indigenous, folk medicine, fringe medicine** or **ethnomedicine**. Some writers refer to non-official healing, which implies that the Western or modern model is the normative and legitimate type of medicine (Maclean & Bannerman 1982:1815). The use of the term **primitive medicine** is ethnocentric and likewise reflects a narrow Western focus (Press 1980:46). Maclean and Bannerman (1982:1815) even find the use of the term **traditional** problematical as it suggests that both the treatment in question and the practitioners are old-fashioned, inappropriate and inadequate.

Not one of the terms in general use is altogether satisfactory as each implies a central body of knowledge, principles and skills shared by the wide variety of indigenous or traditional forms of medicine. In actual fact, the characteristics of traditional medicine vary among societies, cultures, environments and agricultural systems. In this report **African traditional medicine** signifies "... the totality of all knowledge and practices, whether explicable or not, used in diagnosing, preventing or eliminating a physical, mental or social disequilibrium

and which rely exclusively on past experience and observation handed down verbally from generation to generation" (WHO[1] *in* Good *et al.* 1979:142-143).

4.3 Traditional healer

What today is generally known as the **traditional healer** was until fairly recently described as a **witchdoctor**. This name is, however, growing obsolete as a result of the negative connotation which is ascribed to it due to a semantic shift. Actually "witchdoctor" signifies a doctor who has to "cure" witchcraft, analogous with an eye-doctor who treats eyes. Gradually the term assumed the meaning of a doctor who is also a witch - therefore a witchdoctor (Last 1986:15). In this report preference is given to the terms **traditional medical practitioner** or **traditional healer**. These are defined by the WHO (Oyebola 1986:224) as: "[S]omeone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and beliefs regarding physical, mental and social well-being and the causation of disease and disability in the community".

Blacks in South Africa may choose from two main categories of indigenous healers namely the **diviner** and the **herbalist** (Farrand 1984:779). The distinction between these two types of healers is, however, no longer all that clear, mostly as a result of the overlapping of roles: one and the same person often performs different functions such as divination, healing, etc. The distinction is also based on the purpose for which the healer is consulted, namely *ngaka* in the case of benevolent purposes and *baloi* in the case of malevolent purposes. The distinction is thus made for analytical purposes and also because it would appear that the traditional healer, though commanding various skills, does, however, assume a dominant role and can therefore be characterized as one or the other.

A third type of healer category is more recent in origin, namely the **prophet/faith healer** who divines and heals within the framework of the African Independent Churches (AIC). Here we find a syncretism, a re-interpretation of orthodox Christianity in such a way as to be reconcilable with traditional culture. The prophet (*moprofeta*) is therefore not a traditional healer in the strict sense of the word, but has nevertheless the following in common with the traditional healer (Green & Makhubu 1984:1072):

- a shared theory in respect of health and illness;
- a similar means of divination (although they are assisted by God or the Holy Spirit rather than by the ancestral spirits), and
- the treatment of various diseases, including the so-called culture-related syndromes.

5. RESEARCH METHODS

In respect of approach, the investigation falls within the ambit of medical sociology which implies a twofold relationship, namely that between society and the phenomena of disease and health and *vice versa*. This investigation, in part, embraces the tradition of "the

sociology of medicine" and also in part that of "the sociology in medicine", in that the researchers, through this investigation, aim to generate knowledge which, while contributing to the expansion of the corpus of knowledge of sociology as such, can also assist in solving problems related to health care delivery.

This research concerns itself with the following:

- A **micro/macro** analysis of the traditional medical system. The micro-analysis is conducted in respect of health behaviour of individuals/groups, as well as the status-roles and relationship patterns which characterize this system. In the macro-analysis the traditional medical system is placed in context next to other medical systems (modern medicine in this case). In either case the purpose and the method are to explore and to describe.
- A **critical-analytical** and a **critical-comparative** approach in which the nature, as well as the strengths and weaknesses of modern and traditional medicine and also of the possible collaboration between the two are scrutinized.
- ***Ex post facto* research** because the respondents on the one hand already belonged to the different levels of the explanatory variables before the survey was done and on the other, because the researcher could not exercise control over these variables. It was, moreover, impossible to take all the distorter variables into account. As a result of the *ex post facto* design, causal relationships could not be indicated, but only an interdependence between variables.

5.1 The survey

Subsequent to a comprehensive study of relevant literature, existing knowledge related to the topic in question was analyzed and systematized. On the strength of this analysis and systematization the necessary measuring instruments for an empirical survey were developed. The very first step was a survey conducted in Mangaung during May 1989 by means of an interview schedule.

In constructing the questions use was made of dichotomous questions, multiple-choice questions, contingency questions and statements with specific response categories. A number of unstructured (open) questions were also included in the interview schedule. After submission to various experts, including sociologists, methodologists and an anthropologist, the interview schedule was finalized and translated from English into Sotho by a Sotho-speaker. Notwithstanding the fact that the Sotho and Tswana groups in Mangaung are equal in number, it was decided that English and Sotho interview schedules would suffice, as upon enquiry it appeared that any respondent was in full command of either language. Besides biographical details of the respondents, particulars in connection with the following matters were obtained with the interview schedule:

- views on disease causation
- degree of religiousness
- degree of westernization

- utilization of the services of different types of medical facilities and practitioners
- reasons for not consulting traditional healers
- choice of facilities and/or medical practitioners for specific illnesses/conditions
- attitude with regard to co-operation between traditional and modern medical practitioners

The interviews were particularly lengthy, especially in the case of people who consulted traditional healers. This could certainly have affected the responses negatively. Moreover there is reason to believe that there was an underresponse in the study. A possible reason for this was the fear of respondents, on the one hand of sorcery should they make any comments on the topic and, on the other, of being censured by the church should they admit their involvement with traditional medicine.

The interviewers were seventeen Vista University (Bloemfontein) students. Most of these were either Sociology or Psychology students who already had theoretical knowledge of research. About half were Sotho-speakers and the other half Tswana-speakers. Prior to being sent into the field, these interviewers had thorough training with regard to the purpose and importance of this study, the interview schedule and the techniques of interviewing. The aim of the training session was also to equip the interviewers in order to make them acceptable to the respondents, to enable them to handle respondents' questions without leading them, to probe effectively, and to reflect responses accurately.

At the end of each interview schedule there was a form which had to be completed by the interviewer. Here the interviewer had to comment on the degree of co-operation received from the respondent, and also any other remarks of importance. The process of gathering data took two weeks and was controlled by the researcher on a day-to-day basis.

A random sample was drawn from the total Mangaung population by means of multistage cluster sampling. In 1985 the black population of Bloemfontein (Bloemfontein municipal area and Mangaung) was 109 050. Bearing in mind the average annual growth, the population figure for 1989 was extrapolated to 120 462 (Van der Merwe 1990). For the purposes of drawing a sample, use was made of a newly-compiled set of lot maps of the Department of Geography at the University of the Orange Free State. In these, Mangaung was divided into 17 zones according to geographical size and not according to suburb. Although the zones are geographically comparable, the populations of the different zones differ in numbers.

During the first phase of the sampling, six of the seventeen zones were randomly drawn on a proportional basis. During the second phase, 215 living units were selected according to the same principle from six zones. No specific respondent was selected for interviewing in any given living unit. Any available adult of 25 years of age who was willing to co-operate was used as a respondent. As a result of the time-consuming nature of the interviews, a gift was handed to each respondent after an interview. From the sample of 215, 207 schedules were eventually suitable for computer processing and analysis. Owing to the sensitive nature of the investigation it was only to be expected that in certain cases respondents would not be willing to respond. However, not one of the interview schedules was for this

reason totally unusable. The eight schedules which were not used, were omitted because it was found that the specific interviewer had been dishonest.

As a result of the limited size of the sample, provision could not be made for multivariate relationships among items. The validity of the chi-square test was limited and the generalizability of the findings was influenced accordingly. The fact that the respondents in the selected households were not randomly selected, could have brought about a bias in that the interviewers chose respondents with the highest educational level and also from the highest professional categories. To these respondents traditional medicine was less acceptable than to people with a lower educational level and lower professional category.

The data collected during the survey were processed by the SPSSX computer program.

The members of the survey group were fairly young, married persons with a reasonably high educational level and were in professions with a relatively high status. Most of them were of Sotho or Tswana extraction, had lived in Mangaung for the greater part of their lives, were Christians, and were reasonably westernized.

Information contained in the 1985 census was used for a closer description of the respondents. From this it appeared that the **male: female ratio** of the survey group was more or less similar to that of the black population in Bloemfontein as a whole: 46,9: 53,1 % as opposed to 46,4: 53,6 %. The **age composition** of the survey group and that of the total black population correlated fairly well: the ratio younger:older of the survey group was 54,1:45,9 % and that of the total population 62,5:37,5 %. Here it should be borne in mind that the survey group was restricted to persons above the age of 25 years.

There were two reasons in particular why the age categories were restricted to only two: those 45 years and younger, as the **younger group** (54,1 %) and those above 45 years, as the **older group** (45,9 %). Because the median is situated between 36 and 45 years, 45 years was taken as the cut-off point. The first reason for the grouping arises from the fact that 207 respondents is a relatively small sample. So as to enable the researchers to make use of certain statistical tests, the categories had to be decreased due to the problem of low cell frequencies. In addition, the distinction between a younger and older grouping was important to the survey, because it was expected that there would be significant differences between the groups in respect of many aspects of the survey.

With regard to **educational level** there was no correlation between the survey group and the greater population. As with age composition this question, too, was reduced to two broad categories. In this case the median was Std 8; lower was therefore taken to signify a low educational level (63,2 %) and a qualification higher than Std 8, as a high educational level (36,6). The category "other" was disregarded. The relatively high educational level of the survey group gave rise to the expectation that traditional views could not be generally held. The bias in the sampling could probably be ascribed to the fact that it was not specified who was to be interviewed. In such circumstances the choice would naturally fall on that person with whom the interviewer could best or most easily communicate, most probably the younger person. Had the interviewers preponderantly chosen more aged respondents, there could have been a distortion in respect of age, which was not the case.

There is an almost exact correlation between the survey data and the census data with regard to **cultural affiliation**. This variable was important, especially because it was expected that it would play a significant role in respect of various aspects. Here too it was decided to reduce the existing categories to two, namely a Sotho/Tswana group (76,8 %, population 73,7 %) and a Nguni group - Xhosa and Zulu – (20,7 %, population 23,2 %). ("Other" was again disregarded.) Firstly, it was expected that the groups would differ significantly in respect of aspects such as attitude towards traditional medicine, consultation of traditional healers and views on disease causation. Secondly, such reduction of categories was essential with a view to the application of certain statistical tests.

The fact that 98 % of the survey group indicated that they were **members of various churches**, gave rise to the expectation that there would be an underresponse with regard to consultations with traditional healers. Christians, especially, are prone to feeling guilty if they resort to "pagan" practices and could therefore be likely to underreport (Watts 1980:589). Besides this, the responses of the survey group indicated a high degree of piety, as was recorded in respect of the frequency of church attendance and prayer: 75,1 % of the respondents attended church at least once every fortnight, while 70,2 % prayed daily. Because the neo-traditional healer (faith healer) is connected mainly with the AIC, the attitudes that members of these churches revealed in respect of traditional medicine, as opposed to members of other denominations, were especially important to this study. Religious denomination was thus an important explanatory variable.

A very small percentage of the survey group indicated that they lived according to tradition. From this it can be deduced that the members of the survey group were to a great extent westernized. In order to gauge the **degree of westernization**, use was made of a technique based on self-evaluation and standardized by the HSRC in terms of a three-point scale (Schmidt 1976). Educational level is a facet of this process in that it provides the means by which a person can move towards westernization. Almost 40 % of the survey group (36,6 %) had a higher qualification than Std 8 which seems to corroborate this statement. Another factor which indicates the degree of westernization, is the period of domicile in Mangaung. By far most of the respondents had lived in Mangaung longer than 20 years, while 73,3 % reported that they had always lived there. As a result of influx control measures that were until recently enforced, Mangaung can be characterized as being a reasonably closed area. The inhabitants were therefore not excessively exposed to outside influences, such as immigrants from rural communities. Moreover, Mangaung is geographically situated near Bloemfontein where the majority of these inhabitants work. It can therefore be assumed that the respondents were largely exposed to Western customs and practices.

5.2 In-depth interviews

As a result of the sensitive nature of the survey and also all the concomitant problems of cross-cultural research, it was believed one could, in fact, arrive at a more thorough understanding of the problem by using a variety of research methods, i.e. by applying different approaches to the same problem (Walker 1985:20). Supplementary to the quantitive survey, qualitative research could make a contribution towards the

interpretation of the research problem, towards illustrating it and qualifying it. Qualitative data was gathered by means of unstructured interviews with traditional healers, as well as by means of conversations with experts/interested parties in the area of traditional medicine.

During the planning phase the intention was to have one unstructured interview with each of about ten traditional healers. During the pilot study it was, however, realized that a single interview would not be enough to gather the necessary information or to make any kind of sense of the totality of a person's attitudes, feelings and views. It was therefore decided to work longitudinally and, over a period of three years, to conduct several interviews with only three traditional healers - representative of the three identified types. Aware of the problem that "... the presence of a stranger, particularly an observer, in a natural human situation introduces some measure of disturbance in the scene" (Schatzman & Strauss 1973:58) - the more so in a cross-cultural contact situation - it was hoped more frequent contact would, in time, integrate and normalize the interviewer's presence.

Besides contact with the herbalist, diviner and faith healer, the researcher also wanted to make contact with a bishop of a secret prayer group; in fact, during a telephone conversation an appointment was made, but just before the meeting, it was again cancelled. There was also another group of traditional healers with whom the researchers had wanted to have an interview, because they appeared to be against any contact with modern medicine and regarded such contact as a threat to their own cultural heritage - which they jealously guarded. Over a period of three years every attempt at liaison with this group of so-called traditionalists failed.

Initially it was decided that the interviewer would not go into direct interaction with the respondents during the interviews, but that she would work through an interpreter. The reason for this *modus operandi* was to prevent any information from being lost or to prevent certain information being wrongly interpreted. The first interviews were conducted along these lines. Problems were, however, experienced from the outset, as there was protracted communication between the interpreter and the respondent while only the gist of what was said was reported to the interviewer. Because the interviewer feared that information could therefore in fact be lost, and also due to the fact that all the respondents were reasonably fluent in one of the official languages, it was decided to abandon this technique. It was also borne in mind by the interviewer that this technique would lead to no more than an acquaintanceship between the interviewer and the respondent, while the actual goal was the establishment of a relationship of mutual trust (Schurink 1986:46-48). The interviewer is satisfied that this goal was eventually accomplished, partly as a result of the fact that she was acceptable to the respondents as she had also had a Sotho name since childhood, namely *Malerato* ("Many people love her"). The latter serves to illustrate the principle contained in Vidich (1969:81): "There seem to be no cases where field workers have not found a basis on which subjects react toward them." Establishing a relationship of mutual trust is also the method along which validity and reliability are assured in qualitative research (Schurink 1986:53).

The first interviews were conducted with the aid of an interview schedule. Questions or themes which appeared to be important in existing literature were used as a guideline in

conducting the interviews (Schurink: 1986:45). Once this had been done, the interviewer concentrated on specific matters that needed further elucidation. Information was thus gained on the following subjects:

- the different types of healers
- the training of traditional healers
- the *modus operandi* of traditional healers (diagnoses, treatment, healing agents, rituals)
- specialization
- co-operation/referral to other traditional healers
- utilization of/referral to the modern medical sector
- causation of illness
- patient load
- remuneration practices
- membership of professional associations
- manpower situation

The interviews were recorded on tape and transcribed as soon as possible after recording. Notes in connection with the interview situation were also compiled directly after the interview. The notes encompassed all information about the venue, the time and the nature of the interaction. The transcriptions of the interviews were thematically categorized and systematized and, where applicable, related to the literature study.

CHAPTER 2

MODERN AND TRADITIONAL MEDICINE IN AFRICA: A JUXTAPOSITION

1. INTRODUCTION

In the developing world there are mainly two types of health traditions - modern and traditional. Although the modern/traditional dichotomy is the accepted distinction, it must be treated with circumspection, because it is an oversimplification and a misinterpretation of the empirical reality (Morris 1986:368; Young 1983:1205). Nevertheless, it is a useful distinction for the analysis of the two systems: they are juxtaposed with a view to identifying and analyzing the implications of syncretization, dual use and direct competition (Press 1980:46). Modern medicine could accordingly be typified as the historically Western, hospital-based, technologically orientated, structurally dominant system, as opposed to traditional medicine as the culturally/relativistic, structurally subordinate system.

In an attempt to evaluate these two medical systems in Africa as health care systems use is made of the guidelines suggested in Coe (1978:413). He gives the following five requirements which must be met by a care system:

- availability
- accessibility
- affordability
- acceptability
- accountability

In the discussion of modern and traditional medicine affordability is treated as an aspect of accessibility.

2. POSITION OF MODERN MEDICINE IN AFRICA

The modern health care system, based on Western science and technology, is very recent in origin in the greater part of the Third World. In Africa its use dates from the late nineteenth century, the period of colonial intrusion and Christianization and also of the rise of capitalism. In the early years all doctors were foreigners, missionary doctors and colonial medical officers who often practised modern medicine with great success. The introduction of antibiotics in the middle of the twentieth century further expanded their contributions. Immunization campaigns and non-medical developments, like improved provision of water, dramatically decreased the mortality rate. "Yet, in recent decades, once euphoric expectations for the orthodox model of modern medical care in Africa have subsided in the face of growing awareness of its many limitations" (Good *et al.* 1979:146).

2.1 Availability and accessibility of modern medicine

At the macro-level the effective provision of modern health care in Africa, as elsewhere, is curbed by the resources which are allocated to health. Not only is much less of the GNP spent on health compared with other components, but there is a decided decrease in the allocation to the health component. A further problem in Africa as a whole is the number of medical and paramedical personnel in relation to the existing health situation, and also the quality of this personnel. Not only is there an absolute shortage of all types of health workers, but everywhere there is also a maldistribution of such workers which aggravates the situation. In South Africa the maldistribution in respect of health care personnel is the following: 65 % practise in metropolitan areas, 11 % in cities, 6 % in small towns and only 5 % in rural areas (Pillay *in* Savage 1986:65). It is especially the national states which are worst off. Three sets of ratios illustrate this statement:

- **Doctor: population:** In 1976 there were 482 doctors in the national states with a (low) estimated population of 8,4 million. This boils down to an overall doctor:population ratio of 1:17 400. Some individual areas are worse off, for example 1:19 000 in Transkei (1981); 1:17 500 in KwaZulu (1982); 1:20 000 in Gazankulu (1976); 1:30 000 in Lebowa (1982) and 1:116 000 in QwaQwa (1982).
- **Clinic: population:** Only three of the national states conformed to the WHO norm of one clinic per 10 000 of the population, namely Ciskei, Venda and KaNgwane. In KwaZulu the ratio is 1:26 000 (1981) and in QwaQwa 1:16 000 (1981).
- **Hospital bed: population:** The global ratio in the national states is one bed for every 340 persons, compared with the national average of 1:80 (Savage 1986:63).

2.2 Acceptability of modern medicine

Not only are modern medical services inaccessible to most rural populations, but the meagre health care which is in fact available is inappropriate to their health care needs as it is either a remnant of the colonial period, or it was to a great extent imported without adaptation and with insufficient resources (Savage 1986:59). Thus, regardless of the availability of modern health services, social and cultural factors can result in a position where this type of service is not considered to be desirable for the treatment of certain illnesses.

2.3 Accountability of modern medicine

The term "accountability" is used by Coe (1978:413) to signify that "... [p]roviders are responsible for assuring the quality of services rendered, both technically and organizationally, to monitor continually the scientific competence and the continuity of services provided". It therefore encompasses all the foregoing aspects of availability, accessibility and acceptability. The lack of health services to provide for the basic health needs of Third World countries, despite the attempts of governments and international

organizations, is well known. For this reason modern medicine in Africa has continually been under direct attack for more than a decade.

Scepticism and criticism with regard to modern medicine is no new phenomenon, neither is it limited to Africa. It has, however, during the past three decades, become more severe as a result of the increasing disillusionment in respect of the efficacy of medical care. This has motivated numerous health analysts to investigate the supposed relationship between improvement in health and medical care. They have come to the conclusion that modern medicine is overrated and that modern medical care, at its best, was less effective in bringing about a decrease in morbidity and mortality than doctors alleged and than was generally accepted (Pretorius 1984:38; Savage 1986:66). In Africa, Western medicine is criticized for its poor availability and inappropriateness: "The main argument has been that the system that developed in Western industrialized countries has been transferred warts and all to the developing world, where it has failed to have any impact on the total health situation of these countries" (Kriel & Beuster 1977:167).

3. POSITION OF TRADITIONAL MEDICINE IN AFRICA

Before whites settled in Africa traditional medicine, with its tangle of magic and religion exerted great political influence over public and private matters. With the advent of the early missionaries in Africa, the opinion was held that the African could be won by demonstrating that Western medicine was superior in comparison with traditional medicine. All traditional healers were accordingly regarded as being "'witchdoctors' who exploited the ignorance and superstitiousness of the unenlightened natives" (Rappaport 1980:81). Under such missionary influence, and also as a result of repressive political policies, the colonial administrators prohibited traditional medical practices and condemned them as being "heathen" and "primitive" (Ulin 1980:1). Other factors which strengthened the campaign against traditional medicine were, *inter alia*, Western methods of education and the integration of African subsistence economies into the world capitalistic system which led to new values, preferences and patterns of behaviour, and eventually to the disintegration of traditional African cosmology and culture. Yet, traditional medicine survived because most Africans follow a dualistic pattern of consumption.

Although it cannot be denied that certain Africans benefitted from Western medicine, the leaders of the newly independent countries found themselves in unenviable positions during the 1950s and 1960s. Their heritage consisted of a few large, expensive hospitals, inaccessible to the majority of the population; a dire shortage of trained health personnel or health manpower; high morbidity and mortality rates and a passive population, psychologically enslaved to a paternalistic administration (Ulin 1980:2). It is therefore in no way surprising that the attempts to redress disease and malnutrition during the first decades of national independence - as was also the case during the colonial period - met with little success. The governments of the developing world were thus forced to admit that an exclusive system of formalized medicine was both unpractical and detrimental to the public health in those areas where the existing health care resources could not ensure the most basic primary health care. The governments of these newly independent countries

had of necessity to devote attention to the relaxation of legal restrictions relating to the practitioners of traditional medicine and the inclusion of such practitioners into a more flexible system of health care delivery.

3.1 Availability and accessibility of traditional medicine

The available number of medical practitioners in a community is expressed as a ratio of practitioners per numbers of population. Very few studies have been done in Africa in respect of the number of available traditional practitioners, be it at the national, regional or district levels. The estimates which have, however, been made, indicate a very favourable traditional healer:population ratio which varies between 1:108 and 1:847 (Anyinam 1987:804; Green & Makhubu 1984:1072-1073; Harrison 1979:200; Morris 1986:368). No official figures are available for South Africa, so that we have to rely on the traditional healers' associations for indications in this regard. Locally, there are two organizations who claim to be the umbrella body for traditional healers' associations. The South African Traditional Healers Council (SATHC) has 11 branches with a membership of approximately 175 000. However, this association has no branches in the Orange Free State which indicates that this number does not include all healers (Dawson 1989). Towards the end of 1989 the African National Healers Association (ANHA) broke away from the SATHC[2], and this body currently claims to have a membership of more than a 100 000 (Rakolota 1990). Because the degree of overlapping in respect of members between the two associations cannot be determined, the membership of the SATHC will have to be accepted for purposes of calculating the healer:population ratio. Allowing for the estimated black population of 35 million, and the conservatively estimated number of traditional healers of 175 000 (not all obtain membership of an association), the traditional healer:population ratio can be estimated at 1:200. In Mangaung this ratio appears to be more favourable than the estimated national figure. The membership of the largest traditional healers' association, the African Dingaka Association in Mangaung, stood at 756 in 1989 which, with a population of approximately 120 000, means a healer: population ratio of 1:160. There are two traditional healers' associations in Botshabelo[3], each with a membership of approximately 600. Given a population of 207 000 (De Vos 1989-1990), this means a healer:population ratio of 1:172. In contrast, it has already been indicated that the healer: population ratio in most African countries is generally very low (see 2.1). The arithmetic healer: population ratio could however be meaningless, if the type and quality of the services rendered are disregarded.

It is frequently said that the services of traditional healers are more accessible in Third World countries because - compared with modern medicine - it has the advantage of cultural, social, psychological and physical (geographical) proximity.

Given the healer: population ratio, geographical proximity does indeed appear to be a reality, although it would appear that distance is not a deterrent when it comes to consulting a traditional healer. Often a person prefers to consult a traditional healer in another area, on the one hand because the client expects the traditional healer to identify the problem without anyone informing him/her about it and, on the other hand, because the person (a neighbour perhaps) who has harmed the client, may also consult the same

healer. In the survey in question in Mangaung the aspect of distance was also tested. The finding upholds this principle, namely that patients prefer to consult traditional healers elsewhere - especially in the case of diviners and herbalists.

Besides geographical accessibility, economic restrictions likewise influence the utilization of a particular health care service. Not all consumers have the financial means to benefit from the available services. Although it is generally accepted that traditional medicine is cheap and affordable - and although that may have been the case decades ago - the situation has definitely changed. According to various studies and as was verified in this study, the cost attached to seeking help in the traditional medical sector, is often higher than is the case in the modern health sector. In the past decade or so high inflation caused a sharp increase in the cost of traditional medical services as result of the price increases in relation to transport, apprenticeship and training. So as to obtain the prescribed herbs and other ingredients, patients and their families have to make a considerable capital outlay, especially in situations where certain species of plants or ingredients are rare. The range of available species in savannah areas is also decreasing as a result of the accelerated population growth, urbanization, veld fires and droughts.

Other significant factors influencing the pattern of utilization of traditional medicine are age structure, parental approval or disapproval, friends and neighbours, social class structures, the degree of health knowledge of family and friends, the "knowledge" and "awareness" of qualified healers, attitudes in respect of illness, and also values and belief systems.

3.2 Acceptability of traditional medicine

When a particular service is both available and accessible, the next prerequisite for its use is that it shall be acceptable to the consumer. It is imperative that the nature of the acceptability of each service be determined, as the capacity of the service is normally limited by the number of people prepared to make use of it. The degree to which traditional medicine is acceptable to policy makers/governments and modern health personnel is also important and will be discussed further on (See Chapter 4, Paragraphs 3.1.1 and 3.1.2).

The acceptance and utilization of traditional medicine by health consumers in South Africa cannot be called in doubt and cannot, apparently, simply be obliterated. In this vein Karlsson (Karlsson & Moloantoa 1986:29) related how he launched a campaign in Northern Transvaal to obliterate all forms of "traditionalism" in a hospital and in the district served by it. Very soon, however, he had to admit that he could not win the "war", and accordingly he attempted to bring about communication and co-operation.

In the recent past some researchers noted a decrease in the clientele of the traditional sector. Foster (*in* Anyinam 1987:808) indicates that modern medicine is increasingly becoming the first choice of most people for most illnesses. It is only when and if doctors and other medical health personnel do not rise to the clients' expectations that they turn to alternative forms of help, including traditional healers. Various authors (Anyinam 1987; Cavender 1988:251; Karlsson & Moloantoa 1986:43; Mkwanazi 1987:35) are, however, of

the opinion that traditional healers are drawing more and more patients, and especially from the higher social strata. A survey among black first-year medical, paramedical and dental students at Medunsa serves to illustrate this point (Elliot 1984). Three significant findings emerged from this research:

- Two-thirds to three-quarters of the students had very strong supernatural convictions.
- There was a general acceptance of the idea that sorcery is a real force in the world.
- It was generally accepted that the primary causes and sources of most diseases could be ascribed to evil spirits.

Holdstock (1979:119) indicated earlier that there was sufficient reason to assume that a large proportion of the black population would have an increasing need for spiritual values and belief systems. One of the reasons given for this is the increase in psychiatric illnesses resulting from acculturation. He also foresaw that the unique political situation in South Africa would aggravate the detrimental results stemming from acculturation. Holdstock saw the ever-increasing number of traditional healers in townships like Soweto, as confirmation of this assumption.

3.3 Accountability of traditional medicine

The requirement of accountability in respect of traditional medicine is difficult to gauge and is a requirement which can only properly be met once the traditional medical system has attained a different legal position. Reference has already been made elsewhere to South African legislation in this respect (See Chapter 1, Paragraph 2; Chapter 4, Paragraph 3.1.1).

4. COLLABORATION BETWEEN MODERN AND TRADITIONAL MEDICINE

From the above it is clear that modern and traditional systems differ in terms of availability and quality of care, technology and social adaptability. In fact, both have the same aims, namely to promote health. While anthropologists and professional health practitioners for many years were of the opinion that the traditional and the modern medical systems were rivals, there was, for the majority of patients, no inconsistency in the dual utilization of the systems (Jansen 1983; Mankazana 1979; Spring 1980; Yoder 1982a). This was possible because Africans have a dualistic outlook on life which accommodates both the conspiracy theory of witchcraft and the scientific theory of modern medicine. This phenomenon of dual utilization is significant because it provides a basis for linking traditional and modern medicine.

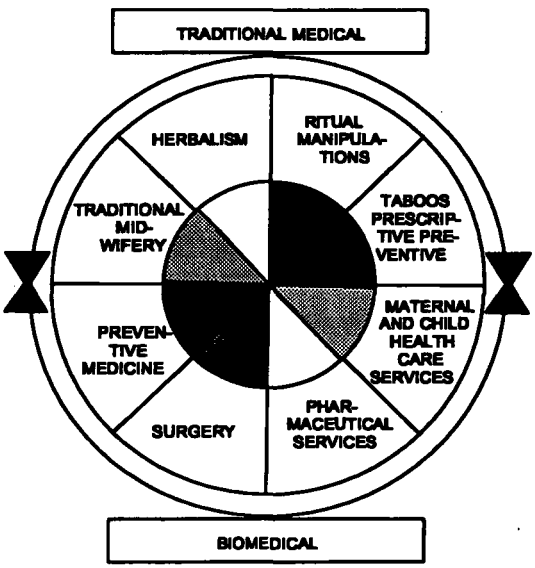
Up to the 1960s the growing acceptability of traditional healers was based mainly on the assumption that they shared certain qualities with their Western counterparts. Subsequently various researchers, however, started investigating traditional practice in terms of own merit, thereby coming to the realization that modern and traditional systems

were devoting their energies to different facets of the process of healing. The Western clinician places emphasis mainly on **what** is wrong and attempts to treat the symptoms. The traditional healer, on the other hand, rather focuses on the **why** and looks into the anxiety which accompanies the disease. Put differently: Modern medical practitioners diagnose and treat disease (abnormalities in the structure and functioning of bodily organs and functions); traditional healers treat illness (human experience of disease). From these insights one comes to the conclusion that Western and traditional medical systems can co-exist independently in a given society, as they throw light on different aspects of the process of disease. It is, moreover, suspected that changes in the relationship between modern and traditional medicine will have a greater influence on factors such as cost, accessibility and satisfaction, than will changes directed solely at the modern care system.

It was the WHO - especially after the Alma Ata Conference in 1978 - who provided the necessary impetus towards collaboration between traditional and modern medicine. It was their firm belief that there was sufficient commonality between the two systems not only to make linking possible, but also to integrate the two systems. In particular it is the collective, community-oriented activities of traditional medicine that correspond with the community-oriented primary health care programmes of modern medicine: "From the former there come health precepts such as balance, rhythm, coolness, purity, and plenitude, and from the latter essential prerequisites of these states such as adequate and clean water, infant care, sewage facilities, adequate nutrition, and good housing, all organized within local communities (Janzen *in* Green 1988:1126).

The scheme in **Figure 1** can be used to conceptualize the conditions that need to be met when the issue of linking the two medical systems is raised.

Figure 1: Traditional medical *versus* biomedical: an analogical model



Source: Spring 1980:59.

From this figure it is clear that each aspect of the traditional medical system can by linked to the modern medical system and *vice versa*. So the counterpart of herbalism is to be found in pharmaceutical services, while traditional midwifery corresponds to the area of maternal and child health. The surgical aspects of modern medicine correlate with ritual manipulation, examples being bone-setting, blood-letting and foreign object extraction. The final category, namely traditional taboos which aim at prescribing appropriate health behaviour and prohibiting actions which may threaten health, corresponds to preventive health measures in the modern medical system.

In order to create a new syncretic type of national health-care delivery system, traditional medicine can be made relevant and its efficacy increased by means of either complementarity or integration.

4.1 Complementarity/Co-operation

When the relation between traditional and modern medicine takes on this form, it means that the two systems co-exist but that they are independent of each other, each respecting the unique character of the other. Co-operation implies a better working relationship between the two sectors: appropriate referrals between the sectors occur regularly, certain skills of the traditional healer are upgraded, while the cultural sensitivity of modern health care practitioners is enhanced (Green & Makhubu 1984:1077). It is, however, imperative that the ultimate goal of co-operation between modern and traditional medicine should be improvement in the quality of patient care and should not merely be undertaken "... to increase the understanding of practitioners of the 'alternatives' available or to serve as a stop-gap measure until biomedical care can be expanded" (Yoder 1982a:1856).

4.2 Integration

The WHO (1978:16) describes effective integration as a synthesis of the merits of traditional and modern medicine by implementing modern scientific knowledge and techniques. The underlying assumption is that the characteristic skills of certain traditional healers can be adapted effectively in order that these healers receive appropriate training to be able to cope with certain modern practices and to transmit certain modern medical beliefs. In various countries the successful integration of traditional midwives has been accomplished. The integration of herbalists has often also been suggested.

5. CONCLUDING REMARKS

From the perspective of non-westerners, especially that of the developing world, modern medicine appears to be a two-edged sword. On the one hand, it holds the promise of treatment and demonstrable effective assistance for a whole series of conditions for which previously there have been no true cures. On the other hand, there is very little doubt that modern medicine, its philosophy, basic assumptions, etc. represents culturally foreign elements which are often associated with colonialism and Western exploitation. Modern

medicine with its emphasis on advanced technology, high cost, specialized personnel and effective medication has also to a large extent failed to cure the illnesses so common in Africa. But at the same time it should be mentioned that the available data suggest that the major proportion of health care in the developing world (75 % - 90 %, depending on locality) is provided by the traditional medical system. The utilization of Western medical services by non-Westerners does not mean that they have thrown their own traditional ideas overboard; in fact, according to Foster and Anderson (*in* Jansen 1983:14) "... traditional peoples show great ingenuity in reconciling scientific medical practices with their own etiological systems ". This phenomenon of simultaneous utilization serves as strong motivation for closer collaboration between modern and traditional medicine.

CHAPTER 3

TRADITIONAL MEDICINE IN MANGAUNG

1. INTRODUCTION

Generally prevailing assumptions about traditional medicine in Africa are that this form of health care enjoys wide acceptance throughout the continent, that its practitioners know the social-cultural background of the population they serve, that these practitioners are held in high esteem and that their work is highly respected. It would appear that both rural and urban areas are viable fields for practising traditional medicine. In more isolated areas this form of care is the only source of help. Research in various large African cities, including Nairobi (Kenya), Dar es Salaam (Tanzania), Ibadan (Nigeria), Lusaka (Zambia), Kinshasha (Zaïre) and Kampala (Uganda) indicates that traditional healers also play important roles in these cities. In a self-help town like Nairobi's Mathare Valley, the geographical distance between traditional healers is generally less than 70 metres (Good *et al.* 1979:145).

Opposed to positive views in respect of traditional medicine, there is also the view that "[o]nly those patients who want to die fast should continue with traditional medicine" (Karlsson & Moloantoa 1986:29). Good *et al.* (1979:145) states that the lack of modern medical services and the inaccessibility of these services are driving an increasing number of people in rural Africa to untrained and unscrupulous "witchdoctors". Ngubane (1981:365) also remarks in regard to the practices of traditional healers in urban areas in South Africa that the control and discipline of traditional healers which is provided by means of their traditional pattern of organization, has virtually no parallel in the urban set-up. Here there is a confusing, stormy situation in which a variety of self-appointed practitioners (also quite a number of charlatans) are practising.

Assumptions concerning traditional medicine are often made without substantive proof of in-depth analysis. In this investigation the aim was to determine what the real role and utilization of this type of medicine was in the urban area of Mangaung by describing and analyzing the patterns of utilization in that pluralistic medical milieu, the degree of acceptance of traditional medicine, and also the attitudes in respect of collaboration between modern and traditional medical sectors.

2. HELP-SEEKING BEHAVIOUR IN MANGAUNG

From responses to certain questions set to the respondents, it was clear that they held a high opinion of modern medicine which probably attests to the acceptability of this type of care. The responses to the questions concerning the medical facility or practitioner who delivers the greatest contribution towards ensuring a healthy community in Mangaung and towards curing the illnesses of inhabitants, are reflected in **Table 1.**

Table 1: The care institutions/practitioners who make the biggest contribution towards health and healing in Mangaung

Care institution/ practitioner	Pursuit of health		Healing	
	N	%	N	%
Hospital	112	54,1	118	57,0
Clinic	24	11,6	16	7,7
Black private practitioner	13	6,3	15	7,2
Faith healer	4	1,9	4	1,9
Herbalist	3	1,4	3	1,4
White private practitioner	2	1,0	2	1,0
Other	49	23,7	49	23,7
TOTAL	207	100,0	207	100,0

That the white medical practitioner in private practice is placed last, can probably be ascribed to the fact that such practitioners do not practise in Mangaung. This is also the reason for separating the categories white and black doctors in private practice. The importance of the hospital and clinic can clearly be deduced from **Table 1**. Note that the diviner does not figure here at all. This is probably because the curing of illness *per se* is not seen as the main function of the diviner.

The way in which help is sought was also determined by means of a list of diseases or conditions. Respondents were requested to make a choice from eight categories of medical facilities and practitioners in respect of each. For the purposes of interpretation these categories were combined and recoded, as set out in **Table 2**, so that comparisons between modern and traditional medical systems could be made.

Table 2: Choice of care institution for specific diseases/conditions

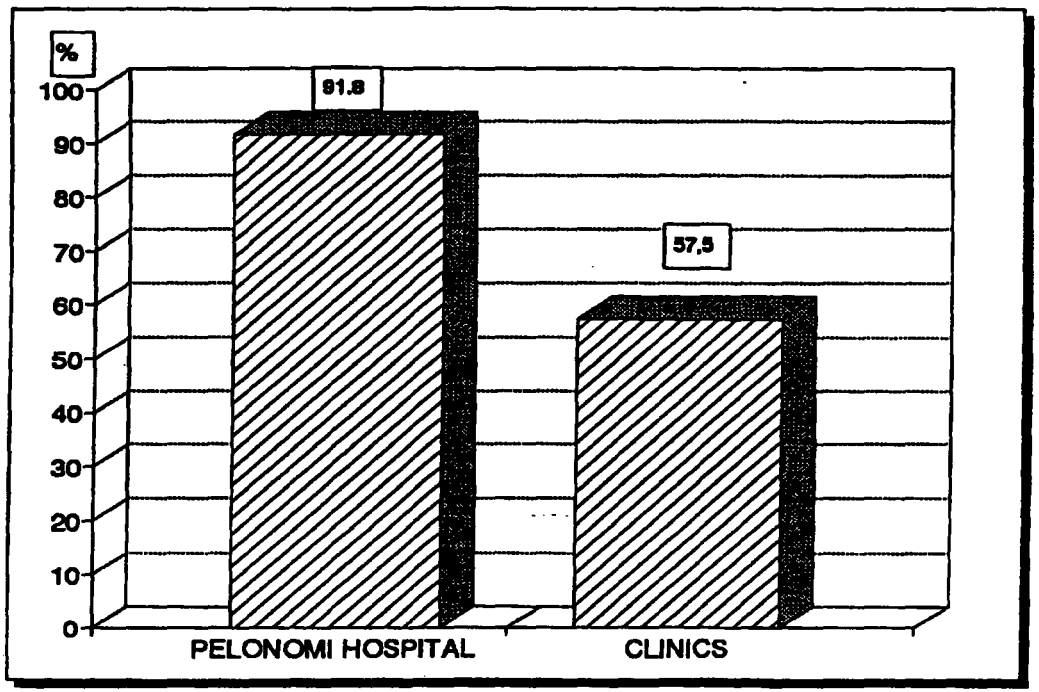
Disease/condition	Choice of care institution							
	1 Only modern medicine	2 Only traditional medicine	3 Other	4 Combination modern/modern	5 Combination modern/traditional	6 Combination traditional/traditional	7 Combination modern/other	8 No response
	%	%	%	%	%	%	%	%
Measles	76,8	1,0	0,5	19,3	1,0	-	-	1,0
Anxiety	63,8	7,7	6,8	11,6	4,3	0,5	1,0	4,3
Insomnia	65,2	7,7	4,3	12,6	4,8	0,5	0,5	4,3
Burns	85,0	1,0	-	5,8	-	1,0	0,5	6,8
Activities of *tikoloshe*	1,4	48,3	8,7	-	1,0	8,7	0,5	31,4
Fractures	91,3	0,5	-	6,8	-	-	-	1,4
Dental problems	79,7	0,5	-	18,8	-	-	-	1,0
Earache	79,9	0,5	-	14,0	2,4	-	-	3,4
"Poisoning" (*sejeso*)	22,2	38,2	5,3	5,3	3,4	6,8	-	18,8
Tuberculosis	76,3	0,5	-	21,7	1,4	-	-	-
Venereal disease	77,3	1,4	-	15,5	2,4	-	-	3,4
Diarrhoea	77,3	3,4	-	15,5	1,4	-	-	2,4
Skin problems	76,8	0,5	-	21,7	0,5	-	-	0,5
Cold/flu	70,0	0,5	-	28,0	0,5	-	-	1,0
Hypertension	72,5	1,9	-	15,9	2,4	0,5	0,5	6,3
Threatening of the house	0,5	44,0	12,6	-	-	8,7	0,5	33,8
Vomiting	76,8	4,3	1,9	11,6	2,9	0,5	-	1,9
Infertility	54,6	8,7	1,0	20,8	9,2	1,9	0,5	3,4
Headache	64,7	1,9	-	27,5	3,9	0,5	-	1,4
Mental illness	77,8	2,9	-	9,2	8,2	1,0	-	1,0
Cancer	85,0	1,4	-	10,1	1,4	0,5	-	1,4
AIDS	72,0	2,4	-	17,9	5,3	-	-	2,4
Diabetes mellitus	80,7	1,4	-	17,4	0,5	-	-	-
Tiredness	66,7	7,2	2,4	16,9	3,4	-	0,5	2,9
Constipation	73,4	2,4	-	19,3	1,9	-	-	2,9

It is patently evident from this table that the greater majority of the respondents preferred modern care institutions for treatment of all illnesses or conditions, except those assumed to have magical origins.

2.1 Consultation of modern health care institutions/practitioners

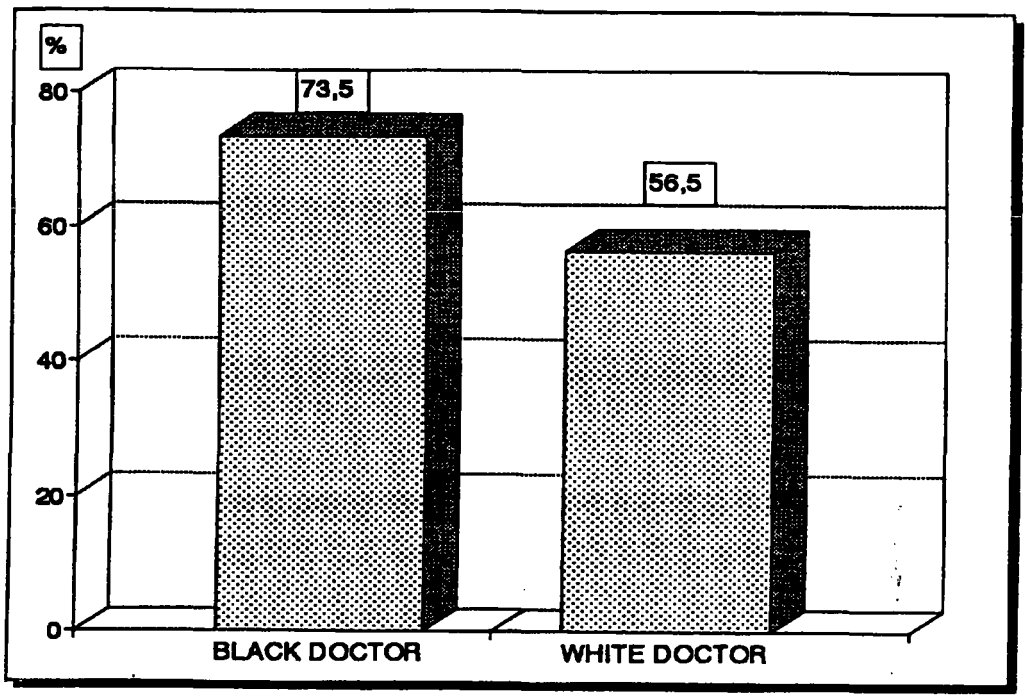
The degree of acceptance of modern medicine is revealed principally in the utilization of care institutions and the services of the modern medical system. The frequency with which the hospital and clinics are used, is reflected in **Figure 2.**

Figure 2: Treatment received at Pelonomi hospital and clinics



The other medical services which are available to the inhabitants of Mangaung are black and white medical practitioners in private practice, although the latter do not practise in Mangaung but in Bloemfontein city. **Figure 3** reflects the frequency with which they are utilized.

Figure 3: Frequency of utilization of services of modern medical practitioners



The degree of acceptance of the modern medical system is also evident from the relatively large proportion of the survey group who utilize both black and white medical practitioners. It has already been said that white practitioners do not practise in Mangaung. Given the fact that most persons who are economically active also work in Bloemfontein city, it would be safe to assume that it is perhaps easier for them to consult the practitioner there. As the fees of black and white practitioners are, according to the patients, almost the same (see **Figure 5**), the reason for the difference in frequency of utilization between the two may possibly be sought in the greater acceptance of black medical practitioners.

Respondents were also asked as to the degree of satisfaction with all the above-mentioned services and facilities. The responses are summarized in **Table 3**.

Table 3: Degree of satisfaction with treatment received at Pelonomi hospital and clinics and from black and white physicians

Care institution/ Practitioner	Degree of satisfaction											
	Very satisfied		Satisfied		Uncertain		Dissatisfied		Very dissatisfied		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Pelonomi hospital	72	37,5	96	50,0	4	2,1	19	9,9	1	0,5	192	100
Clinic	41	34,7	67	56,8	7	5,9	2	1,7	1	0,8	118	100
Black doctor	75	49,3	74	48,7	1	0,7	2	1,3	-	-	152	100
White doctor	43	37,1	65	56,0	2	1,7	5	4,3	1	0,9	116	100

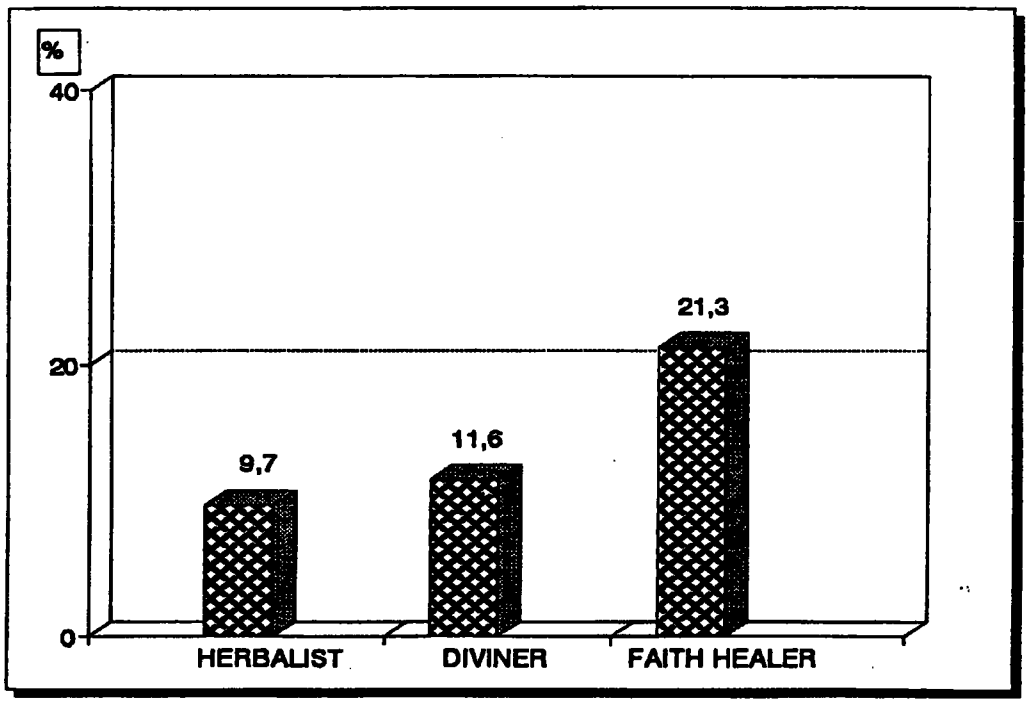
The greatest degree of satisfaction was expressed in respect of the black doctor, then the clinic and white doctor and finally Pelonomi. The greatest degree of dissatisfaction was expressed in respect of Pelonomi, even though this dissatisfaction was not at a high level.

2.2 Consultation of traditional healers

During the survey on the role and utilization of traditional healers in Mangaung, the consumers of medicine prescribed by such healers, were not purposively selected. Had the purpose simply been a description of the different types of healers, their *modus operandi*, views on illness, etc., it would have been better to have selected only consumers. More reliable information of better quality would in all probability have been gathered. However as the researchers wanted to determine **patterns of utilization** and **help-seeking behaviour** when more than one medical system was available, and also the **attitude towards co-operation** between the modern and traditional medical sector, the sample had to be selected from all the inhabitants. Because of the relatively small proportion of respondents who consulted one of the three types of healers, these responses can only be described. Exactly the same questions were asked in respect of each type of healer so as to make comparison possible.

Of the 207 respondents, 73 (35,6 %) indicated that they consulted traditional healers. The percentage of the survey group who utilized the different types of healers is reflected in **Figure 4.**

Figure 4: Percentage of the survey group who consulted traditional healers*



* This percentage does not add up to 35,6 %. Although 73 of the respondents consulted traditional healers, there was an overlapping so that there were six who consulted a diviner and a herbalist, four who consulted a diviner and a faith healer, two who consulted a herbalist and a faith healer, and one who consulted all three types.

Before aspects such as the reasons for consultation, frequency of consultations, and the degree of satisfaction with treatment are discussed, the consumers of the services of each of the three types of healers are compared in terms of a number of variables (**Table 4**).

Table 4: Consultation of traditional healers according to different variables

Variable	Traditional healers		
	Diviner (N = 24)	Herbalist (N = 20)	Faith healer (N =44)
	%	%	%
Gender			
Male (N = 97)	50,0(12,4)[a]	50,0(10,3)	43,2(19,8)
Female (N = 110)	50,0(10,9)	50,0(9,3)	56,8(22,9)
Age			
45 years and younger (N = 112)	37,5(8,0)	30,0(5,5)	47,7(18,9)
Older than 45 years (N = 95)	62,5(15,8)	70,0(14,9)	52,3(24,5)
Level of education			
Low[b] (N = 131)	86,4(15,1)	77,8(11,2)	63,6(22,2)
High[c](N = 76)	13,6(4,1)	22,2(5,6)	31,8(19,7)
Cultural affiliation			
Sotho/Tswana (N = 159)	56,5(8,2)	85,0(10,9)	79,1(21,5)
Nguni (N = 43)	43,5(23,3)	15,0(7,0)	20,9(21,4)
Religious denomination			
European-oriented mission church (N = 135)	54,2(9,6)	35,0(5,3)	63,6(20,9)
Orthodox AIC (N = 23)	33,3(17,8)	40,0(17,8)	25,0(24,4)
Non-orthodox AIC (N = 45)	12,5(13,0)	25,0(21,7)	11,4(22,7)
Occupation			
Economically inactive/ unemployed persons	58,3(17,9)	60,0(15,8)	45,5(26,0)
Unskilled labourers	25,0(13,0)	15,0(6,5)	27,3(26,1)
Half-skilled workers	12,5(12,0)	15,0(12,5)	4,5(8,3)
Skilled workers	4,2(9,1)	5,0(9,1)	6,8(27,3)
Semi-professionals	—	5,0(4,5)	9,1(18,2)
Entrepreneurs	—	—	—
Professionals	—	—	6,8(15,0)
Extent of westernization			
Traditional life-style (N = 29)	25,0(21,4)	20,0(14,8)	18,2(28,6)
Western life-style (N = 60)	4,2(1,6)	15,0(5,1)	15,9(11,5)
Equally traditional and Western (N = 118)	70,8(14,4)	65,0(11,0)	65,9(25,0)

a Figures not in brackets indicate the percentage of consumers belonging to a particular variable. Those within brackets are the proportional figures relative to the total sample.

b Low = Std 8 and lower.

c High = higher than Std 8.

An analysis of the data in **Table 4** indicates the following:

- There were as many male as female consumers of the services of both the diviner and of the herbalist, with a slight predominance of females consuming the services of the faith healer.
- In all cases most of the consumers of services of traditional healers fell in the higher age bracket. When it came to the consultation of faith healers the difference between the older and younger groups was, however, considerably less than with the other two types of healers.
- In respect of educational level, most consumers fell in the category "low educational level". What is significant was the marked difference between the two categories of consumers: the consultation of diviners was six times higher in the group with a low educational level than in the category "high educational level". In the case of the herbalist it was approximately three times higher and in the case of the faith healer it was two times higher. If consumers with a high and a low educational level, respectively, are expressed as percentages of the total survey group, the large difference between the two groups in respect of consultation of diviners and herbalists is maintained, while it is virtually cancelled in the case of the consultation of a faith healer, with 22,2 % of the low educational level group and 19,7 % of the high educational level group consulting this type of healer.
- Although the Sotho/Tswana group appears to be the largest percentage of the utilizers, it is a function of the fact that this group constituted almost 77 % of the survey group. For purposes of interpretation the percentage of consumers is expressed in relation to the total survey group. According to this, both the Nguni and the Sotho/Tswana group consulted the faith healer equally frequently, slightly more of the latter group consulted a herbalist, while the Nguni group consulted the diviner much more frequently than the other group. If all the Sotho/Tswana consumers are added together (64), it appears that 40 % of this group consulted traditional healers in comparison with 51,2 % of the Nguni group.
- As the numbers of the members of the different religious denominations included in the survey differ, the same procedure is followed as was the case with cultural affiliation. There was very little difference between the white oriented mission church and the orthodox and non-orthodox AIC in respect of consultation of a faith healer. Members of the non-orthodox AIC were the largest consumers of the services of the herbalist, and the members of the orthodox AIC of the services of a diviner. The members of the non-orthodox AIC appeared to be the largest consumers of the services of traditional healers (27 of the 45 members = 60 %), followed by the members of the orthodox AIC (13 of the 23 members = 56,5 %) and those of the white oriented mission church (48 of the 135 members = 35,6 %).
- The majority of the consumers of the services of all the types of healers were economically inactive and in the case of the diviner and faith healer they were also unskilled labourers. Those with a higher professional status (skilled and professional workers) mainly consulted faith healers.

- Those who followed a traditional life-style consulted all three types of traditional healers to a greater extent than did those with a Western life-style or those with a life-style that fell between traditional and Western.

Approximately 32 % of the survey group visited one or more traditional healers during the twelve months preceding the survey. The frequency with which traditional healers were consulted, is reflected in **Table 5.**

Table 5: Frequency of visits to traditional healers in the preceding twelve months

Consultations	Traditional healers		
	Diviner	Herbalist	Faith healer
	%	%	%
1-2 times	50,0	50,0	52,3
3-4 times	29,2	15,0	15,9
5-10 times	8,3	5,0	9,1
More than 10 times	12,5	10,0	15,9
Not once	–	20,0	6,8
TOTAL	100,0	100,0	100,0

This utilization of traditional healers (31,9 % during the preceding 12 months) was considerably higher than the 17,8 % who in a survey conducted during 1978 among urban blacks in the Transvaal, Natal and the Orange Free State (De Beer 1979:4), indicated that they had visited a traditional healer in the 12 months preceding the survey. On the other hand, it was comparable to the findings of Farrand (1984:780), although her sample consisted only of psychiatric patients and they were asked only about visits to **diviners** in the preceding 12 months. Here there was an affirmative response of 28 %.

A number of possible explanations for the utilization of traditional healers were suggested to those who utilized such services (N = 73, i e 35,6 % of the survey group). The responses are tabulated in **Table 6.**

Table 6: Reasons for consulting traditional healers

Reasons for consultation	Traditional healers		
	Diviner	Herbalist	Faith healer
	%	%	%
Because they are trusted	91,3	95,0	86,4
Because they live nearby	4,2	5,0	11,4
Owing to illness	7,5	100,0	86,4
Because they are successful	66,7	55,0	74,4

The responses in connection with distance once again reflect that this factor is of very little importance (see Chapter 2, Paragraph 3.1). Although the different types of healers were all trusted to the same degree, the herbalist was apparently considered to be less successful. Those respondents whose answers were in the affirmative in terms of the above-mentioned reasons were requested to supply further reasons for each. From these it was clear that the main reason for trusting traditional healers was connected with the success they considered these healers to have. In the case of the diviner and the faith healer the respondents were very satisfied that they were free of the problem and less so, though still highly satisfied in the case of the herbalist. The degree of satisfaction with the treatment of traditional healers was generally very high. None of the respondents reported that they were dissatisfied with the treatment by the herbalist and the diviner, while only very few (6,8 %) appeared to be dissatisfied with treatment by the faith healer.

3. ACCEPTABILITY OF TRADITIONAL MEDICINE

Besides that portion of the survey group which admitted to consulting traditional healers, the acceptability of traditional medicine can also be deduced from the following indications: the importance of traditional healers as opposed to, for example the importance attached to God and the church, the attitude towards traditional healers as reflected in the responses to certain statements, and also the reasons for non-use of these types of services.

3.1 Importance of traditional healers

For purposes of comparison the respondents were asked not only to indicate the degree of importance of each type of healer, but also to indicate the degree of importance of the ancestral spirits, God and the church in terms of a Likert scale. Although the respondents had to react to this question according to a five point scale, it was reduced to three for purposes of interpretation, without changing the original meaning. The responses are reflected in **Table 7.**

Table 7: Importance of traditional healers, ancestral spirits, God and the church to respondents

Response categories	Importance			
	Important	Uncertain	Not important	No response
	%	%	%	%
Church	96,6	1,4	2,0	–
God	92,8	1,0	2,9	1,4
Prophet	39,1	18,4	39,6	2,9
Ancestral spirits	31,9	18,4	40,1	9,7
Herbalist	31,9	15,5	48,8	3,9
Diviner	16,4	22,7	56,0	4,8

These responses are in accordance with the typification of the research group as being predominantly Christian with a Western life-style. However, when the extent of importance is compared with the actual consultation of traditional healers, it becomes apparent that in each case importance is higher than utilization frequency (see **Figure 4**): The herbalist was regarded as important by 31,9 % as against 9,7 % who consulted him/her; 39,1 % regarded the faith healer as important, as against 21,3 % who consulted him/her. In the case of the diviner the difference was significantly smaller: 16,4 % regarded the diviner as important, as against 11,6 % who consulted him/her.

3.2 Attitude to traditional healers

Another indicator of the acceptability of traditional medicine is the attitude of the survey group to traditional healers, as reflected in responses to the statements "Traditional healers must be banned" and "Medical doctors must learn more about traditional healers". The responses to these statements are tabulated in **Table 8**.

Table 8: Responses to the statements "Traditional healers must be banned" and "Medical doctors must learn more about traditional healers"

Statements	Response categories					
	Agree strongly	Agree	Uncer-tain	Disagree	Disagree strongly	Total
	%	%	%	%	%	%
Traditional healers must be banned	5,0	4,0	27,4	40,8	22,9	100,0
Medical doctors must learn more about traditional healers	29,3	47,3	17,6	4,4	1,5	100,0

The attitudes of the respondents to these statements and also the two other indicators, namely utilization of traditional healers and views on the importance of these healers, were used as a control in an attempt to gauge the acceptability of this type of health care practitioner. Only 9 % agreed/strongly agreed with the statement that traditional healers should be banned, and 63,7 % disagreed. Almost 76 % held the view that medical doctors should get to know more about these healers, while only about 6 % disagreed.

3.3 Reasons for non-utilization of traditional healers

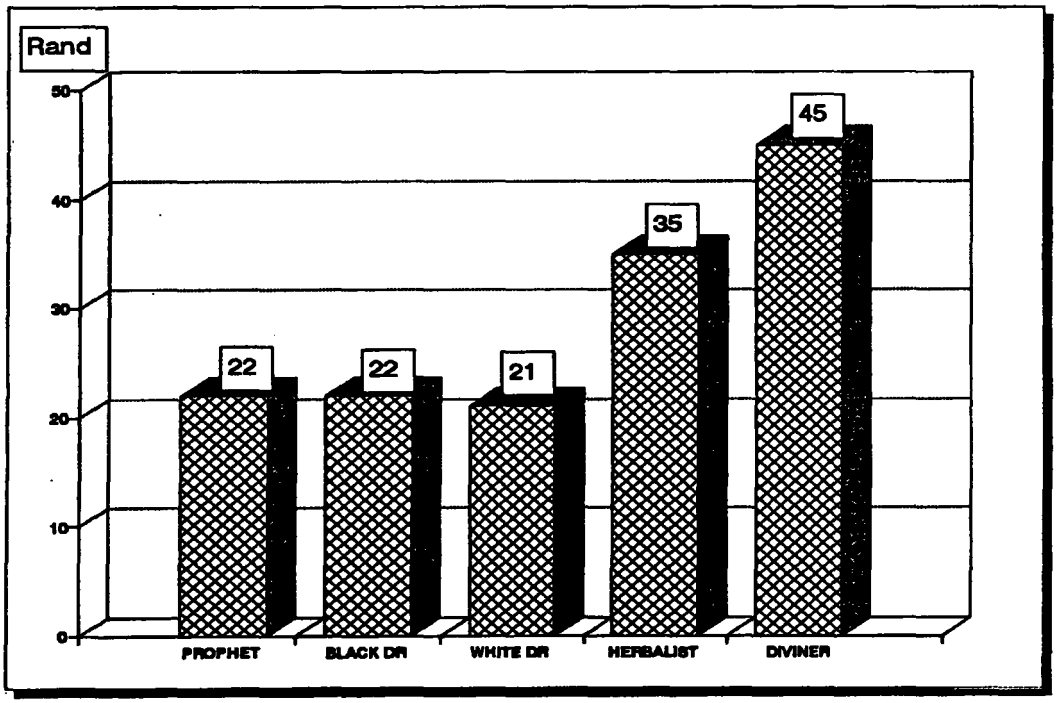
All the aforementioned indicators, together with a high traditional healer:population ratio, bring us to the conclusion that this type of medicine enjoys a reasonable degree of acceptance in Mangaung. In order to give the full perspective on the acceptability of traditional healers, it is also necessary to take note of those who do not utilize the services of such. Reasons for non-utilization are set out in **Table 9**.

Table 9: Reasons for non-utilization of traditional healers

Reasons	N	%
Clash with Christian religion	86	53,1
Distance	15	9,3
High cost	2	1,2
Other reasons	59	36,4
TOTAL	162	100,0

From this it is evident that the cost factor was not a significant deterrent to the utilization of traditional medicine. According to all indications the consultation fees of herbalists and diviners were considerably higher than those of modern medical practitioners and faith healers.

Figure 5: Consultation fees of medical practitioners



During the interviews with traditional healers in Mangaung, Mrs C, the faith healer, stated that the maximum fee for a diagnosis was R2. The expectation, however, existed that a patient would return to thank the faith healer if he/she had been cured. The fees of the herbalist and of the diviner varied in relation to the condition or illness which was treated. In the case of "ordinary" illnesses, the standard fee was R10. For an illness like cancer Mr W, the herbalist, could charge up to R1 000. He would not give free treatment if a person returned to him to say that he/she had not yet been cured. For every new diagnosis, payment had again to be made. Mrs A, the diviner, charged R100 to drive off the *tikoloshe*.

Two possible reasons can be advanced for consulting traditional healers, despite the relatively high cost. In the first place, little value is attached to inexpensive or even free health care services. Secondly, it once again affirms the aspect of cultural relevance.

4. ATTITUDE OF INHABITANTS REGARDING COLLABORATION BETWEEN MODERN AND TRADITIONAL MEDICINE

In view of the dual utilization of modern and traditional medicine, it was necessary also to determine how the inhabitants actually view any form of formal collaboration between the two medical sectors. This was established from responses to six relevant statements, summarized in **Table 10.**

Table 10: Responses to statements regarding the linking of modern and traditional medicine

Statements	Response category					
	Definitely agree	Agree	Uncertain	Disagree	Definitely disagree	Total
	%	%	%	%	%	%
1. Traditional healers should be allowed to work in hospitals like medical doctors	15,0	27,5	33,5	15,0	9,0	100,0
2. Medical doctors should refer patients to traditional healers in cases of physical illness	10,4	28,4	30,8	15,9	14,4	100,0
3. Medical doctors should be more positive towards traditional healers	16,4	38,3	28,9	10,4	6,0	100,0
4. Traditional and modern medical healers should never work together	10,4	18,3	27,7	31,7	11,9	100,0
5. Traditional healers should refer patients to medical doctors in cases of physical illness	26,6	44,8	24,1	3,4	1,0	100,0
6. Traditional healers should acquire some of the skills of medical doctors	24,1	45,3	22,7	4,9	3,0	100,0

If the responses to the two statements in connection with referral to other medical practitioners (the second and the fifth) are compared, it is apparent that there was a much greater positive response in the case of referral by a traditional healer to a physician (71,4 % - "definitely agree" and "agree") than was the case when the position was reversed. There was, however, still a reasonably positive attitude towards referral to traditional healers (38,8 %).

The chi square test for independence reflects that the gender, cultural affiliation and degree of westernization of the inhabitants of Mangaung are related to their attitude in respect of the statement in connection with referral of patients by physicians to traditional healers. Although there was not a very strong relationship with regard to gender, the relationship in the case of the two other variables was reasonably strong.

If **Table 11** is analyzed, it appears that the Nguni group were more negative in respect of this statement and that the greatest degree of uncertainty (37,4 %) was to be found among the Sotho/Tswana group.

Table 11: Relationship between cultural affiliation and the statement that doctors should refer patients to traditional healers in cases of physical illness

Cultural affiliation	Doctors should refer patients to traditional healers					
	Definitely agree	Agree	Uncer-tain	Dis-agree	Definitely disagree	Total
	%	%	%	%	%	%
Sotho/Tswana group	10,3	25,8	37,4	14,8	11,6	79,1
Nguni group	12,2	36,6	7,3	17,1	26,8	20,9
Total group	10,7	28,1	31,1	15,3	14,8	100,0

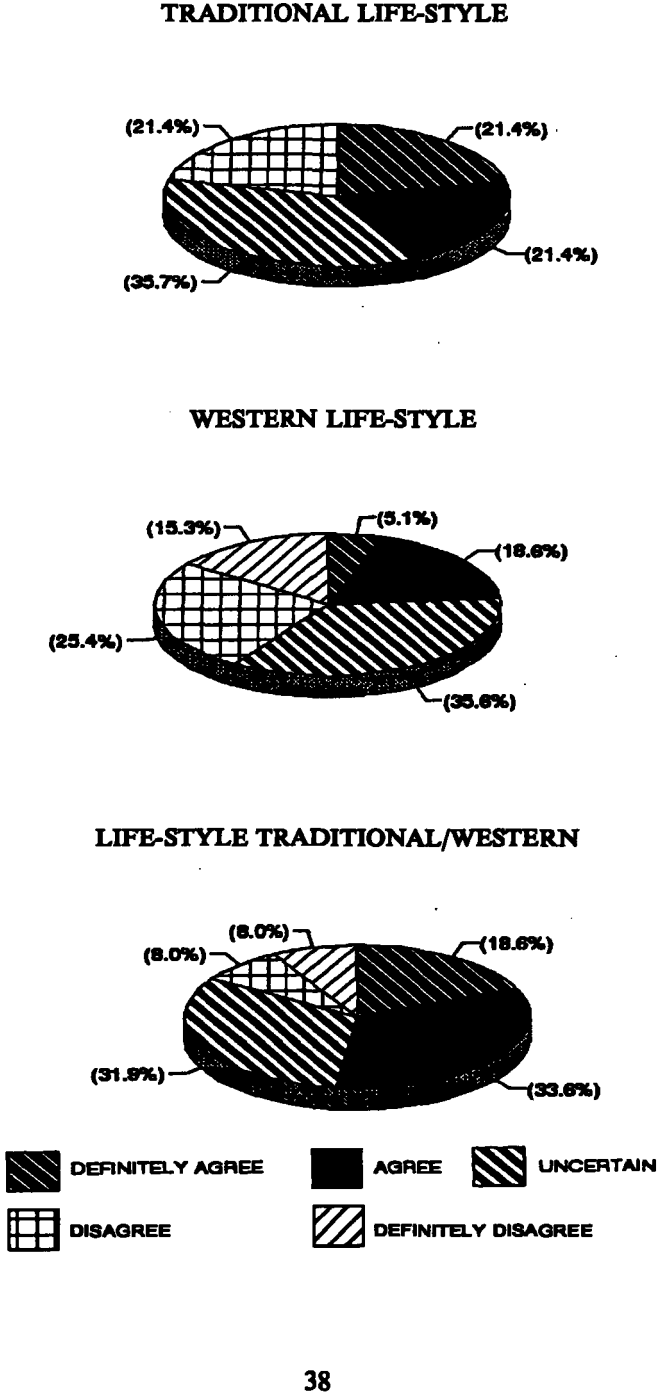
Table 12: Relationship between degree of westernization and the statement that doctors should refer patients to traditional healers in cases of physical illness

Degree of westernization	Doctors should refer patients to traditional healers					
	Definitely agree	Agree	Uncertain	Disagree	Definitely disagree	Total
	%	%	%	%	%	%
Traditional life-style	14,3	32,1	28,6	17,9	7,1	13,9
Western life-style	5,1	11,9	37,3	23,7	22,0	29,4
Life-style equally traditional and Western	12,3	36,0	28,1	11,4	12,3	56,7
Total group	10,4	28,4	30,8	15,9	14,4	100,0

The greatest negative response (45,7 % if "disagree" and "definitely disagree" are added together), as well as the greatest degree of uncertainty (37,3 %), occurred in the case of those who had a Western life-style.

The chi-square test shows that there was also a significant correlation between degree of westernization and the attitude of the inhabitants of Mangaung in respect of the statement that traditional healers should be allowed to work in the hospital. However, this does not appear to be a strong relationship. As a result of the limitation arising from the occurrence of an empty cell, measures of statistical association which indicate the direction of the relationship could not be interpreted. From analysis of the sample data, which relate only to the survey group, it would appear that the respondents were reasonably positive in respect of this statement. The greatest positive reaction was found with that group which had a life-style which was equally traditional and Western (52,2 % if the categories "definitely agree" and "agree" are added together). Even the group with the western life-style reacted reasonably positively (23,7 %). The degree of uncertainty was the same in the three groups. This data is reflected in **Figure 6.**

Figure 6: Relationship between degree of westernization and the statement that traditional healers should be allowed to work in hospitals



A fair indication of attitudes in respect of collaboration between modern and traditional medicine is to be gleaned from the response to the statement that traditional and modern medical practitioners must never work together. Almost half of the respondents (43,6 %) indicated that they did not ascribe to this attitude. The chi-square test for independence once again indicates that the degree of westernization of the inhabitants of Mangaung correlates with their attitude towards co-operation between traditional and modern medical practitioners. The result of this cross-tabulation is significant at the 10 % level ($\leq$ 0,10), and appears to indicate a reasonably high degree of dependence between the variables concerned. This cross-tabulation is set out in **Table 13.**

Table 13: Relationship between degree of westernization and the statement that traditional and modern medical practitioners should never work together

Degree of westernization	Traditional and modern practitioners should never work together					
	Definitely agree	Agree	Uncertain	Disagree	Definitely disagree	Total group
	%	%	%	%	%	%
Traditional life-style	14,3	25,0	25,0	25,0	10,7	13,9
Western life-style	13,8	24,1	34,5	15,5	12,1	28,7
Life-style equally traditional and Western	7,8	13,8	25,0	41,4	12,1	57,4
Total group	10,4	18,3	27,7	31,7	11,9	100,0

From this table it appears that those with a traditional life-style subscribed to the statement in question to the same high degree (39,3 %) as those with a Western life-style (37,9 %). Those with a life-style between the two types were much less inclined (21,6 %) to agree with the statement. More than half of this latter group (53,5 %) disagreed with the statement and therefore displayed a positive attitude to co-operation between traditional and modern medical practitioners.

The respondents reacted very positively to the last two statements, namely that medical doctors should be much more positive towards traditional healers and that the latter should learn some of the skills of medical doctors. In the case of the first statement the positive response was 54,7 % and 69,4 % in the latter case. No significant relationship could be found between both statements and the explanatory variables - gender, age, education level, cultural affiliation, religious denomination or degree of westernization - and therefore no table is provided.

From the interviews with the different traditional healers it was apparent that these persons were not at all averse to referring their patients to the modern medical sector. Mrs A, the diviner, said that she could, for instance, sense that a patient's heart was affected, in which case she would refer such a patient to a medical doctor. Because she was afraid that such a patient could possibly die, she would give no medication. The heart condition first had to receive the necessary attention, before she could further treat such a person. Mr W, the herbalist, also referred in high-risk cases, for instance pregnancy with complication. For this reason all healers had telephones. Even if the patient was not able to pay for an ambulance, Mr W would pay and ask the patient to visit him after he had been discharged from hospital. According to Mrs A, quite a number of patients were referred to them by white doctors who could not cure their patients. Yet, there were also those who could not be helped by their (traditional) methods and who then consulted modern medical practitioners.

Mrs C, the faith healer, also referred patients to the modern medical sector. She described one such case: "*I had a patient whom I saw, you know, this person is a bit nervous. And for three consecutive days I tried to cure the person, but it wasn't* (possible). *It was then that I took him straight to a doctor with my money so that the doctor could determine what was wrong with the person.*" Patients had also been referred to her by the modern medical sector: "*But naturally I have had two patients who were mad, who now as we speak are cured; they are working.*"

5. CONCLUDING REMARKS

To sum up, the following can be stated with regard to the acceptability of modern medicine in Mangaung. The data indicate a very high degree of acceptability, firstly, as gauged by **beliefs about facilities and practitioners who make the greatest contribution in striving for health and healing of illnesses,** secondly, according to the **percentage of the research group which makes use of the modern medical sector,** as well as the **degree of satisfaction expressed in respect of all the applicable services and facilities.**

The degree of acceptability of modern medicine does, however, in no way detract from the acceptability of traditional medicine to the inhabitants of Mangaung. Taking into account the percentage of the survey group which consulted traditional healers and the possibility of underresponse, and judging by indicators such as the degree of importance which was attached to traditional healers, the attitude of respondents to such healers, and also the reasons for non-utilization, this type of medicine likewise enjoys a reasonably high degree of acceptance. Furthermore, it is evident that the inhabitants of Mangaung were generally reasonably positively disposed towards the principle of collaboration between the traditional and modern medical sectors. An analysis of the relevant data leads us to the conclusion that the attitude of the inhabitants indicated a bias towards incorporating the traditional medical sector into the modern medical milieu rather than that the latter should be incorporated into the traditional sector. It also appears that, in respect of collaboration between traditional and modern medicine, the degree of westernization had the greatest influence on the attitudes of the inhabitants.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS AND STRATEGIES

1. INTRODUCTION

The modern medical care model in Africa is criticized because it is crisis-orientated, the more so when it is hampered by financial restrictions, it treats only symptomatically and is dependent on technology. Few resources and little prestige are accorded preventive programmes as a result of the fact that they do not deliver immediate results, although the importance of such is widely recognized. Morley (*in* Good *et al.* 1979:147) alleges: "...[I]n developing countries three-quarters of the deaths are caused by conditions that can be prevented at low cost, but three-quarters of the medical budget is spent on curative services." Nevertheless, and for very good reasons, the demand for modern health care is insatiable. Therefore the main point of criticism is that there is not enough of it.

So as to ensure that health care services are provided to all people in Africa, Harrison (1979:197) names six possible strategies to supplement the manpower shortage in the field of health care:

- training of more doctors, nurses and other health care personnel;
- importing health care personnel from abroad;
- regaining health care personnel who have emigrated;
- reorganizing existing health care personnel;
- training of other non-professional persons to do the work of doctors;
- training of traditional healers to deliver mother and child health services, to aid in family planning and public health services.

The first option which indicates the training of "sufficient" health care personnel according to international standards is not easily attainable in Africa. In fact, it is virtually impossible to achieve as inflation increases world-wide and the financial situation of these countries - especially those who do not produce oil - continues to degenerate. Moreover, such action can be viewed as being relatively extravagant, as it entails between 15 and 20 times the cost attached to the training of one medical/clinical assistant. The strategy of importing foreign health personnel reflects the need for highly trained medical specialists in any developing country. The fundamental need is, however, for health care personnel whose qualifications and life-style (especially a willingness to work in rural areas) is orientated to the provision of primary health care and the treatment and prevention of the most common illnesses.

The large number of doctors who, after training, do not practise in their own countries — mainly because of political instability and inadequate opportunities for professional development — is one manpower resource which could supplement the shortages in

Africa. Even if emigrant health personnel could be regained, their numbers are, however, not such that such a step would make any significant change in the health care situation. Harrison's last three options indicate innovative means of bringing health care to the large number of underprovided populations of Africa. The last option, in particular, touches on the problem of the application of traditional healers in modern health care systems.

Despite the fact that traditional medicine has no right of existence (from *inter alia* a Christian and a legal perspective), it continued to exist up to where we now stand on the eve of the twenty-first century. The year 1978 in which the Alma Ata Conference on primary health care was presented by the WHO/UNICEF was, in many respects, a watershed in respect of interest in traditional medicine on the entire African continent. Up to that point, this medical system existed alongside the modern system, but was functionally unallied in any deliberate sense. As a result of the WHO initiatives the emphasis, however, shifted to culturally adapted local and regional solutions for these parts of the world, in which traditional medicine naturally had a prominent role to play. The time was therefore ripe for modifications and mutual adaptations in the existing health care systems. Divergent views are, however, found in this regard.

There are those who take a positive view of any alternative approach which emphasizes health-supporting actions and life-style. They predict that such an approach will result in a situation where the current expensive, complex and virtually unmanageable health care systems will be replaced by more horizontally-organized, less complex care systems (Aakster 1986:272). There are also those who believe that modern and traditional medicine should no longer go their separate ways in mutual antipathy, as they pursue exactly the same goal, namely the improvement of human health and quality of life (Akerele 1987:181).

Opponents of a linking up of the two medical systems - usually representatives of the conventional medical establishment - refer to the problems connected with the well-known and potentially detrimental results of traditional medical practices. Others again point out the immense cost involved in the testing and certifying of medicaments, and also the licensing and monitoring of practitioners.

The main problem with regard to liaison between modern and traditional medicine is connected with a fundamental irreconcilability between the two paradigms of illness and the accompanying world-views. Modern medicine is rooted in scientific method: illness is viewed as a natural phenomenon which can be explained in terms of physical processes and therefore curable by rational methods. Traditional medicine is, however, to a large extent still pre-scientific. If magico-religious theories and views were to be taken at face-value only, without attempting to reveal the medical message contained in them, one would be confronted by certain philosophical problems which would make one challenge science itself: "... [F]or example, the belief in supernatural beings or forces suggests that there are creatures with enough power to suspend or interfere with the very laws of nature and physical events on which science depends and which it seeks to uncover" (Pearce 1986:240). Holdstock (1979:123), like Maslow, holds a different opinion concerning science: "Before all else, science must be comprehensive and all-inclusive. It must accept

within its jurisdiction even that which it cannot understand or explain, that which cannot be measured, predicted, controlled or ordered."

Notwithstanding the divergent views which are held concerning traditional medicine, there is a marked increase in the prominence of this kind of medicine. There is also an increased tendency for traditional healers to organize themselves, on the one hand, to ensure political advancement through collective action in a plural society, and on the other, to ensure a self-made future (Chavunduka & Last 1986:260). Mention has already been made of the establishment of the SATHC and the ANHA as umbrella organizations for various traditional healers' organizations (Chapter 2, Paragraph 3.1). Their aim of gaining recognition from the authorities, similar to that which is accorded the South African Medical and Dental Council, has, however, not yet been realized (Dawson 1989).

A first attempt at the national level to move beyond possibilities and to put forward a proposal regarding the future role of traditional medicine in a new dispensation in this country was made at a conference hosted by the Centre for Health Policy (Wits) in September 1991. On this occasion representatives of, *inter alia*, the following organizations/parties stated their positions on the future of traditional medicine: the South African Traditional Healers Council, the South African Medical and Dental Council, the health department of the ANC, the Department of National Health and Population Development, the South African Medical Association, the Congress of Traditional Doctors of South Africa and the health department of the PAC. The proposals put forward by the representatives were that traditional healers should be given formal recognition; that a body made up of traditional healers should develop guidelines for the registration of healers, draw up a register of bona fide healers and regulate traditional health care; that there should be close contact between modern and traditional sectors and that mutual referral should take place; that the services of the two sectors should run parallel and not be integrated, and that traditional healing should (for the time being) remain part of private rather than public health care.

What will most probably give strong impetus to the attempt at recognition of traditional healers, are the demands of workers via labour unions for such recognition of these healers. According to the organizers of labour unions the demand is connected not only with the recognition of an already acceptable method of healing, but it also has a political dimension. It, in fact, indicates a person's right to the medical help of his/her choice.

With reference to the above, mention must also be made of the climate of the times. There are, on all sides, manifestations of an increased frankness, increased leniency, and greater tolerance with regard to traditional healers and traditional medicine. The editor of the *South African Medical Journal* (Wierenga 1988:53) states that although there is very valid criticism against the traditional healer he nevertheless believes that there must be much closer co-operation. According to him the traditional healer can learn much from the medical establishment and *vice versa*. He stresses the importance of keeping an open mind and of guarding against preconceived ideas.

Numerous academics (especially psychologists) have for some time now been advocating collaboration between the modern and traditional medical sectors and are involving traditional healers in actions concerning holistic medicine (*Sunday Tribune* 1988:15).

In the Department of National Health and Population Development, there is currently a movement afoot to utilize trustworthy traditional healers in primary health care. Accordingly, the Chief Directorate of Primary Health Care entrusted with education/ information/guidance has for some time now been involved in distributing pamphlets and basic knowledge concerning health matters among traditional healers. A one-week course in primary health care was also recently held for traditional healers in Pretoria (Metelerkamp 1993:20).

So too, bodies like the Wild Life Society of South Africa and the National Botanical Gardens are currently displaying a conciliatory attitude towards traditional healers. The former has for instance undertaken to provide the waste products of game which are used for *muti*. Because scarce medicinal plants are endangered species, Kirstenbosch has launched a project to cultivate suitable tissue cultures. The aim is to provide such tissue to traditional healers at reasonable prices for home culture (*Sunday Tribune* 1988:15; Wierenga 1988:53).

Other bodies which have also already started to co-operate with traditional healers are the National Cancer Association of South Africa, the South African National Tuberculosis Association and the South African Medical Research Institute in respect of AIDS. At the largest gathering to date, 500 traditional healers recently held their annual convention to discuss their role in the fight against AIDS. The aim of the convention - sponsored by a condom manufacturing company - was to convey all the facts about the disease and to make the healers aware of their crucial role in this regard to inform and educate their followers and their prospective communities (*Community Health in Southern Africa* 1992:23).

The traditional healer is also being used more frequently and with great success to stabilize the labour forces of organizations, for example the Chamber of Mines and others such as the saw mills in the case study of Herbst and Britz (1986). In rural areas it is becoming customary for doctors to make informal contact with traditional healers. The result is mutual referral of cases, depending on which medical sector is best able to help in the case of a specific condition (*Vrye Weekblad* 1989:11).

2. CONCLUSIONS IN RESPECT OF THE SURVEY

The main findings of this survey are:

- Traditional beliefs in respect of health, illness and care are embraced by a significant proportion of the black population.
- They consult traditional healers irrespective of the high degree of acceptability of modern medicine, the relatively high cost of traditional medicine, and the churches' negative sanctioning.
- They are positive with regard to collaboration between the modern and traditional medical sectors.

- Urgent attention must be paid to devising means by which traditional medicine can be accommodated in a national health care delivery system.

The first two findings point to the future role of traditional healers, while the latter two indicate that more research on collaboration between modern and traditional medicine is imperative. We now turn to the latter need.

2.1 Need for data concerning collaboration between modern and traditional medicine

"... *[T]he proposals for the 'integration' of medical systems have been launched from a very precarious platform based on unproven premises, in often contradictory language about the efficacy of the different medical systems, or simply without sufficient information at all*" (Pedersen & Baruffati 1989:493).

As early on as 1976 at its meeting in Kampala, the main recommendation of the WHO was that more research needed to be done in connection with traditional medicine before there could be meaningful dialogue about integration and/or collaboration. After almost 15 years the study of collaboration between traditional and modern medicine is still in its infancy. To date there are few examples of the grounds on which the success or failure of future collaboration can be predicted. More knowledge must be gained in respect of the **attitudes of traditional and modern medical practitioners towards each other**. Many more studies concerning both **traditional beliefs, practices and therapeutic agents**, and **patterns of utilization by patients** are needed to give direction to the planning of effective collaboration between the divergent systems (Ulin 1980:9). Other important information which is still required, is connected with the **efficacy of individual programmes**, and the **cost** and the **advantages** and **disadvantages** attached to collaboration in the long and the short term. Even **potential sources of conflict** must also, in addition, be identified (Oppong 1989:611).

Ngubane (1981:365) warns that, should an extremely thorough study of all the above-mentioned aspects be neglected, "... yet another disaster of development could all too easily result".

2.2 Future role of traditional healers

"*Het idee dat hekserij of toverij iets archaïsch is dat vanzelf zal verdwijnen met de modernisering en de 'Entzauberung der Welt' is immers bijzonder hardnekkig in het Westen*" (Geschiere & Van Wetering 1989:150).

When Simons (1957:85), more than three decades ago, referred to the continued existence of traditional medicine, he ascribed it to factors such as the adaptability of this type of medicine, the obstinacy of customs and habits, but mainly to deficiencies in educational facilities and health services available to blacks. He did, however, predict that "[i]t is destined to lose its fight against the law, an erosive modernity, the greater efficacy of hospitals and trained physicians, and the 'new' diseases like tuberculosis and poliomyelitis that fall outside the range of tribal skills".

Like Simons, Foster (*in* Glasser 1988:1462) is convinced that Africans will naturally turn to modern medicine when this type of medicine complies with the following conditions: "[W]hen good scientific medicine is available ... delivered by friendly and sympathetic personnel at a price patients can afford and at convenient times and places, scientific medicine is more and more the first choice." The following questions arise as a result of the views that higher educational standards, the establishment of a scientific climate and also the provision of the necessary health services will lead to the elimination of traditional medicine:

- How long will it take to establish an adequate health care system for everyone in South Africa?
- To what extent can the people concerned, distance themselves from the traditional cosmic model?
- Is it at all possible to eliminate traditional beliefs, or will they continue to exist in modified forms?

For as long as the traditional beliefs continue to exist, Africans will require traditional medicine in the case of illnesses which are defined and explained in a personalistic[4] manner.

All indications are that there are a significant number of local blacks who still have confidence in these beliefs and who therefore still, under certain conditions, avail themselves of the services of traditional healers. In the study in question in Mangaung 29,5 % of the respondents indicated that they had a Western life-style, while 57 % regarded their life-style as being equally traditional and Western. Only 13,5 % had a traditional life-style. The significant number here is the 57 % which represents the inhabitants who regarded their life-style as being neither exclusively traditional nor exclusively Western. Given the perception of this group concerning their life-style, and the troublesome problems in respect of provision of education, it is to be doubted that these persons, as indeed also the rest of the black population, will be able to escape their traditional ties within the foreseeable future. Added to this, 44,6 % of this group still regarded the ancestral spirits as being important in their lives. They also displayed a very positive attitude in respect of collaboration between traditional and modern medicine in that 52,2 % of this group felt that traditional healers should be allowed to work in hospitals.

Although this study showed that there was a high degree of acceptance and utilization of modern medicine by the inhabitants of Mangaung, this did not serve to disqualify their consultation of traditional healers. In spite of the fact that the survey group was relatively young, had a relatively high educational level, were Christians and were reasonably westernized, 35,6 % indicated that they consulted a traditional healer. This utilization of traditional healers also occurred despite the apparently higher cost which it entailed. Neither must we lose sight of the strong possibility of underresponse in this connection.

If we accept the principle that patients should receive treatment in accordance with their culture and world-view, traditional medicine will not be phased out in the foreseeable future. Were this, in fact, to happen a vacuum would exist for those who believe in such medicine and who especially benefit by it psychologically (Glasser 1988:1463).

3. RECOMMENDATIONS

The general deficiencies of the South African health care system are well-known. In order to remedy the problem, all locally available human resources should be optimally utilized. It is therefore inevitable that a balance should be sought between different types of intervention. One of the gulfs that must be bridged is that between the modern and the traditional medical sector.

Having considered all the possible options for collaboration between traditional and modern medicine, it is our opinion that integration of the two systems could be potentially detrimental to both. On the other hand, co-operation, characterized by mutual respect and a willingness to learn from each other, could facilitate the mutual transfer of important values to both systems and could eventually realize the universal goal of "health for all".

3.1 Problem areas in respect of collaboration between modern and traditional medicine

For any linking programme to be successful, it is necessary for four specific groups to co-operate, namely the authorities responsible for health care delivery, the Western-trained health care workers, the traditional healers and the clients. While all of these parties are faced with certain dilemmas, it is possible for these problems to be surmounted by co-operation to the mutual benefit of all concerned. For many African governments such an endeavour could make it possible for them to extend health services in a relatively inexpensive way by utilizing existing community resources. Better and more frequent communication between Western-trained health practitioners and traditional healers could result in health care delivery which is more culturally relevant and appropriate. In the event of the successful linking of the two systems, the position of traditional healers who are a mixed group with no standardized training and no official *locus standi*, would be adjusted dramatically.

Despite the possible merits, certain problem areas cannot be ignored. Four such potential stumbling blocks will be dealt with.

3.1.1 *Acceptance of traditional medicine by governments*

The attitude of governments towards traditional medicine varies from *laissez-faire* to outright rejection, as was the case in Mozambique and Tanzania. Nevertheless, since the collapse of colonialism the African social-cultural identity has slowly been revived and with it traditional medicine as part of that cultural heritage. Notwithstanding the renewed interest, this has not resulted in concrete policy. Only four of the 25 countries in the African subregion for which data are available, have passed legislation in this regard (Ramanohisoa 1983:213-214).

In South Africa the use of traditional healers is officially outlawed. In 1974 the government - and the South African Medical and Dental Council - made their rejection of traditional healing official in a law barring those not registered with this Council (and in

1982 amended to include those not registered with the South African Associated Health Services Professions Board) from performing any procedure pertaining to medical practice. In reality, however, traditional healers continue to practise and are generally not legally harassed by the authorities. Since 1990 the government, who has until recently been mainly concerned with the health of the white population, has developed a national plan based on the concept of affordable health care to all the inhabitants of South Africa. Traditional healing is envisaged as being part of this plan (Freeman 1992).

3.1.2 *Mutual acceptance by traditional and modern medical practitioners*

While most modern medical practitioners appear to be indifferent to traditional healers, there are those who ardently advocate their utilization. Modern medical practitioners are frequently suspicious, even apprehensive of the traditional healer because the latter does not possess "scientific" knowledge and skills. Those who are opposed to traditional medicine are those who come into contact with the failures of traditional healers and have to rectify such failures. Traditional healers often view any contact with either modern medical practitioners or officialdom in terms of legal proceedings, taxation, humiliation or loss of their cultural heritage. It is also true that traditional healers are anxious to change their image as "primitive witch-doctors". It would seem that prestige and recognition are the fundamental incentives underlying traditional healers' willingness to co-operate (Green 1988:1128).

Research findings as to the attitudes of doctors, nurses, pharmacists and other paramedic personnel regarding co-operation are extremely fragmentary and mostly dated. Research done by Ngubane (1981:362) led her to conclude that practitioners of Western medicine in South Africa are generally antagonistic towards traditional healers, while the latter regard Western medicine as complementary to their own medicine, and even as an alternative under certain circumstances.

The degree of acceptability of traditional medicine by modern medical practitioners has a bearing on the quantifiable, rational aspects of traditional practice. Herbal, mineral and animal ingredients have already been subjected to scientific testing. The other dimensions of traditional medicine are generally regarded by modern doctors as being dependent on the esoteric (and dubious) knowledge of specific practitioners whose activities are under suspicion. As a result of the naturalistic orientation of most herbalists, the general tendency is therefore that they enjoy greater acceptance than diviners and faith healers. Medical practitioners are often apt to interpret co-operation as meaning that traditional healers will refer patients to them and not *vice versa.*

According to views expressed by representatives of the modern medical sector at a conference on the recognition and registration of healers, it was clear that unless interventions have been scientifically evaluated, there could be no guarantee of safety. Hence they were reluctant to simply recognize and accept registration of healers (Freeman 1992:66).

It is obvious that such an evaluation of the present attitude and intellectual position of Western medical practitioners *vis-à-vis* traditional medicine is imperative because no

government would consider co-operation or integration if doctors still disparage traditional medicine.

3.1.3 *Legitimation of the non-rational aspects of traditional medicine*

As traditional medicine is governed by a tradition of secrecy, it is to be expected that healers will be hesitant to divulge secret practices, recipes of extracts from medicinal plants and mystic formulae. In addition even the biomedically acceptable part of traditional medicines and practices is sometimes based on belief in the supernatural. The issue of whether such healing methods should obtain official recognition or be incorporated into health care delivery comprises many unique and difficult problems (Stepan 1983:311-312). In some cultures supernatural forces are considered to be of such immense importance in the general conceptions of health and illness that religious rites, invocations, magical methods and all forms of sorcery constitute integral parts of traditional medicine and are indeed applied to the advantage of patients. On the other hand, the possibilities of fraud and of the abuse of such methods are apparent.

Health administrators should make clear distinctions between harmless and harmful practices, rites and beliefs when they are to determine which healing methods should be incorporated within a proposed framework for synthesis.

3.1.4 *Demystification of the traditional healer role*

Although the meaningful utilization of the traditional healer in a national health care system implies that this role should be demystified, certain negative implications cannot be ignored. According to Rappaport (1980:92) demystification entails a process by means of which the critical elements which project the traditional healer's image, are broken down "... if the 'props' upon which his image rests have been neutralized or destroyed". Staugard (1986:67) is even more emphatic in stating that while to modern medicine an integration of itself with traditional medicine might imply short-term advantages, in the case of traditional medicine it would most probably act as a "kiss of death". Green and Makhubu (1984:1077) fear that traditional healers will only become second-rate paramedical workers and that they will not be able to fulfil their important societal function which comprises social, psychological, mental and somatic health dimensions.

As a solution to the problem of demystification Rappaport (1980:95) suggests a model based on the existing informal treatment model which is in general use in Africa, namely that persons move from one sector of the health care system to another in search of healing. This pattern of utilization also has a Western counterpart. Rappaport here refers to a psychosomatic illness such as peptic ulcer. In such cases medication, diet or even surgery are common as first options in the treatment of organic illness. After this the physician frequently refers the patient for psychotherapy as a result of possible underlying emotional problems. This two-phase process is very much like the spontaneous dual pattern of utilization of the modern African. As a result of this similarity Rappaport believes that such a model is practicable in Africa and that it could have the following

features: the modern medical practitioner could treat the symptoms, after which the patient could be referred to a traditional healer who is autonomous and works in another physical milieu. What is important is that the traditional healer functions without his values or image being changed much. In this way an existing trend is continued. By systematizing this trend, it is ensured that the best of both medical systems is used and that the basis on which patients choose the most suitable practitioner for a specific illness, is improved (Yoder 1982a:1855).

4. GUIDELINES AND STRATEGIES FOR COLLABORATION BETWEEN TRADITIONAL AND MODERN MEDICINE

The decision to move in the direction of collaboration will require comprehensive and significant reforms in respect of the definition and organization of health care. Personnel and working relations which characterize the current medical "skills pyramid", will have to be modified and reorganized, while local communities will have to accept a greater degree of responsibility for the type of health care which they receive. The appropriateness and range of specific reforms will differ from one society to the next, allowing for local conditions. An important problem that will have to be addressed is determining what is meant by the synthesis of modern and traditional medicine. It certainly implies more than peaceful co-existence, given the urgent need for optimally utilizing all available health practitioners. What is rather needed, is beneficial co-existence (Neumann & Lauro 1982:1819). An important prerequisite is that the system which so develops will be flexible to such a degree that the individual skills and varying levels of knowledge and education, insufficient resources and a variety of supporting technologies will be accommodated within such a system.

4.1 Prerequisites for successful collaboration

As a prerequisite to an eventual collaboration between traditional and modern medicine in a cross-cultural medical system, the following should serve as guidelines (Koumaré 1983:30; Slikkerveer 1982:1869; WHO 1978:19):

- the exclusion of any inclination towards eliminating traditional medicine by simply adopting such medicaments and techniques as are considered effective;
- the place which is assigned to the traditional healer in the health team must coincide with his skills and abilities;
- the acceptance of the principle of a health care network based on both systems and which is beneficial to the community.

More specifically this means that

- government policy and planning principles should be aimed at the establishment of a structural basis for the process of collaboration;

- academic and educational principles should be aimed at further research, as well as the training of traditional medical practitioners;
- professional principles should concentrate on the acknowledgment of and respect for the various kinds of healing, and
- the principles of public opinion should be aimed at the improvement of participation and of utilization by the different population groups.

In addition to the prerequisites mentioned above it is also important that the acceptance of certain stereotypes in connection with traditional and modern medicine which have gained popularity in the recent past, be guarded against. Should these stereotypes be accepted uncritically as a basis for health planning they could indeed prove to be counter-productive. There are four such stereotypes (Foster 1983:22-24):

- **Traditional medicine is holistic; modern medicine puts the focus only on the disease/ symptoms.** A basic argument which is advanced in favour of the inclusion of traditional healers in primary health care programmes, is that they are familiar with the family backgrounds of their patients. They are thus able to consider both psycho-social and clinical factors in diagnosis and therapy. This argument applies only in the case of relatively isolated villages. Moreover, modern medicine is increasingly moving in the direction of a comprehensive approach by putting the focus on the total patient in his total environment.
- **Traditional healers are relatively old, highly respected people and will, as a result of their status, be valuable allies in primary health care.** It is a gross generalization summarily to say that if healers play their parts well in the traditional milieu, they will fare just as well as formal participants in modern health services. Also the fact that they are older could actually lead to resistance to change. In the final instance, it should also be borne in mind that many of these healers act amorally from time to time.
- **Health care decision making is based on the fact that Africans categorize illnesses in a two-fold manner: the first being diseases which Western doctors can cure; the second being culture-related illnesses which are definitely not acknowledged, and can definitely not be treated, by Western doctors.** In reality recent research indicates that the process of health decision making is influenced by a whole range of factors, among which are economic and social cost, prestige factors, distance, time, comfort, traditional beliefs, the personality or the fame of specific healers, etc. No single model is able to predict help-seeking behaviour in times of a health crisis.
- **Western medical practitioners are often uninformed concerning traditional medicine; they have little understanding of the terminology and the ontology of such medicine and therefore find it difficult to communicate with black patients.** This is an early stereotype developed by anthropologists and based on the image of Western missionary doctors in developing countries. Recent experience would indicate that a growing number of Western medical practitioners do have an understanding of the etiology described by their black patients and that they can communicate with them effectively.

4.2 Specific steps aimed at ensuring successful collaboration

In order to effect the joining of the traditional and the modern medical systems, sufficient knowledge is cardinally important to health care planners. Information concerning traditional medicine which appears to be necessary on a regional or district basis in any society, includes (Akerele 1987:180; MacCormack 1986:161; Neumann & Lauro 1982:1820; WHO 1978:37):

- the numbers and types of traditional healers, their practices and their efficacy;
- current standards and control in the practice of traditional medicine, including training, the existence of professional associations and the use of peer evaluation;
- the utilization of traditional medical practitioners in health services;
- the illnesses which are successfully treated by traditional healers;
- traditional medicaments;
- an estimate of the expected costs and personnel requirements for implementing a large-scale attempt at joining modern and traditional medicine, and
- legal restrictions pertaining to the re-organization of national or local health care systems, and also an estimate of the time, effort and funds which will be required for a revision of existing legislation.

The first essential step in promoting co-operative approaches is **the formulation of relevant national policy**. In this policy provision must be made for legal recognition of traditional medicine. The existing legislation in most countries is, as has already been indicated, mostly obsolete or irrelevant and will have to be revised and brought in line with the new policy directions which are envisaged.

In order to succeed Good *et al.* (1979:149) suggests a bottom-up approach. This means that a real attempt must be made to involve each community with a view to solving their own health problems. Such a step has social, psychological and emotional advantages if individuals who provide primary health care come from within the community and are really an integral part of the local community. This approach has already been implemented with varying success in Tanzania's Ujamaa villages, in Guatemala and in China. According to Bennett (1986:738) most planning is, however, still being done centrally so that communities have orders to select and to utilize community health workers or to have traditional midwives trained. If, however, this were to be done from the bottom up, it is a prolonged process of months or years during which time the community must be made sensitive and aware, management skills must be rounded out and community structures such as the establishment of committees must be developed. Unfortunately donors (and often a large portion of the support of primary health care does come from donors) mostly require that a programme in which people are sensitized, and a number of health workers are selected and trained, be completed within three to five years. Such programmes are also often threatened by the fact that unused funds will have to be returned or that such grants will be discontinued.

A second important step is **influencing the attitudes of traditional healers and Western-trained health workers favourably in respect of co-operation and mutuality** (Akerele 1987:178). On the one hand, specific training programmes for traditional practitioners must be increased; on the other, it is necessary that elements of traditional medicine be introduced into the existing curricula for the training of other health workers, so that greater acknowledgement of the usefulness of traditional medicines and of traditional practices can be brought about.

More specific proposals for strategies which have to be launched in traditional and modern medicine respectively in order to bring about collaboration, will now be outlined.

4.2.1 *Steps in respect of traditional health care*

The specific steps here in question, are referred to by Ademuwagun (1979:163-164), Akerele (1987:180-181), Good *et al.* (1979:150-151) and Neumann and Lauro (1982:1819):

- The establishment of procedures and criteria for the systematic evaluation of the basic knowledge of various kinds of traditional specialists and their diagnostic skills relative to the medical assistants, nurses and midwives who are currently responsible for the provision of state health services in a local area. "First and foremost, of course, the traditional practitioners should be involved in the evaluation of their own practices so as to facilitate the ready acceptance by their peers of suggestions for changes, including the assumption of new responsibilities - for example, in health education" (Akerele 1987:179).

- The establishment of a state licensing programme so as to license medical practitioners who have undergone a specific, acknowledged training or apprenticeship and who already have achieved a predetermined level of competence in their work. This would encourage those who are already practising to improve their skills and would inspire them to seek entry into this high status profession while it would also curb quackery.

- The financing of research in connection with the pharmacopoeia of traditional medicine, especially in respect of medicinal plants. Manuals and didactic material can be compiled with a view to the standardization of doses of plant extracts in use in the traditional medical sector and which could be used in primary health programmes. The purpose of these would be to improve the efficacy and safety of remedies derived from medicinal plants - which often contain pharmacologically active agents and, in the case of an overdose, could have harmful side-effects. Imported medicines are very expensive and consume scarce foreign exchange. The development of traditional remedies of proven effectiveness and quality will promote economic independence.

- Identifying and training traditional midwives who have basic scientific obstetric skills, in order to meet the goal of providing at least one midwife per community. The WHO has been involved in this for years now, as in the case of the Danfa project in a rural area north of Accra (Ghana) with 60 000 inhabitants. Locally, a similar programme

was launched in Botshabelo and 46 traditional midwives have already been identified and trained (Venter 1988).

- Identifying and selecting traditional healers (for example herbalists) to participate in a training programme aimed at the "upgrading" of all their skills in accordance with the norms of the biomedical establishment. Such ancillary personnel must be chosen by the community and be responsible to said community. Training must include *inter alia* hygiene, sanitation, first aid procedures, asepsis and health education. Traditional healers can therefore be enabled to administer simple treatments at the point of first (and even **only**) contact, to assist in local immunization campaigns and to refer patients to satellite clinics in the vicinity. Besides remuneration by the community, state remuneration as an incentive should not be excluded.

- Identifying and utilizing hand-picked traditional healers (magico-religious specialists) as psychiatric support personnel in the community, together with appropriate, unobtrusive, external medical care support.

- Providing communities with small supplies of medicine. This could be made available to the already mentioned traditional ancillary personnel and traditional midwives. The fact that such persons may be illiterate, should not stand in the way of such action. These practitioners are often able to distinguish among hundreds of herb samples. Innovative approaches to the provision of essential medicines is a critical need in view of the chronic shortages and even total unavailability of medicines in rural health facilities as a result of the high cost, uneven distribution in favour of hospital-based healing services, poor management and even mismanagement.

- A flexible, rudimentary system of referral can be encouraged, with the community as the basic cell for primary care. Currently there is no formalized collaboration between traditional healers, Western doctors and other modern health care personnel, in spite of the fact that people - as has already been demonstrated - display a dual utilization pattern. Existing spontaneous flow of patients will have to be directed, improved and possibly optimized. In this way traditional medicine will be linked to a comprehensive national system and to technically higher levels of health care.

On the face of it the foregoing proposals would appear to hold no threat for the traditional health system. Good *et al.* (1979:151) does, however, question the regulative control of this type of medicine, not only because it is foreign to the very nature of such medicine, but also because it will be virtually impossible in the face of the esoteric, non-rational components of this medicine. Moreover, "... regulation should be avoided so as not to drive practitioners underground" (Good *et al.* 1979:151).

4.2.2 *Steps in respect of the modern health care sector*

The following guidelines are proposed by Good *et al.* (1979:150-151) and Neumann and Lauro (1982:1819) in this connection:

- The number of part-time health workers must be significantly increased (in addition, that is, to the selected traditional healers). This will also provide an opportunity to

accommodate some of the surplus unemployed persons with at least secondary education.

- The number of health workers at the intermediate and lower levels must be significantly increased, while they must also take increased responsibility for medical care. During their training and in their period of service, they must be brought into contact with traditional healers. The intention here is a decrease of the "... topheaviness of the modern medical hierarchy" (Good *et al.* 1979:150).
- An increase in locally trained doctors: biomedical training programmes must therefore include elements of traditional medicine with an eye to cultivating an appreciation of traditional beliefs and practices. This will ensure that doctors will be attuned to the realities of local cultural norms and scarce technological aids. This recommendation presupposes the establishment of new medical schools, even in smaller centres and reforms in medical curricula in accordance with specific local needs. Regional medical training programmes would be an extension of this idea, by which a group of medical schools of neighbouring countries would combine their post-graduate medical training programmes. Good *et al.* (1979:151) predicts that "home-trained would be better adapted than foreign-trained, more concerned about priorities of community health care, less frustrated with the lack of technological support, less likely to be exportable and, hence, to be lost in the 'brain drain'".
- Parallel to the broadening of the base of the pyramid of health care providers there is a need for the careful integration of referral systems at each level of care. Good *et al.* (1979:151) envisages referral taking place at five levels in a hierarchy, besides the members of the patient's family who are his first point of contact for health care:

  the local traditional health care ancillary personnel (healers/midwives), to

  the assistant to the community nurse, to

  the nurse, medical assistant or clinical officer, to

  the general medical practitioner, and to

  the specialist medical practitioner.

There is no single or simple approach to the way traditional practitioners must become involved in the national health system. Committed and honest action by all concerned, therefore a collective effort, will be necessary to generate and to implement a suitable policy. To get this important programme off the ground the WHO established a world-wide network of specialized institutions with expert, motivated and enthusiastic individuals who could, as a first essential step, contribute to programme development. Twenty-one such centres have already been established, five of these being in Africa.

5. CONCLUDING REMARKS

In all probability traditional healers in the future South Africa, will, as elsewhere in Africa, play an important role in respect of nationalist interests. Due cognizance will have to be

taken of established professional, financial and personal interests in the way in which the health system is currently organized. Under these circumstances future developments with regard to traditional and modern medicine could not only be based on the inherent abilities of the two methods of healing, but could be influenced and determined by political, economic and social factors.

It would appear as though the time is now ripe for modifications and mutual adaptations in the dualistic health care system of the developing world, especially against the background of the dire shortage of economic resources. It can only be hoped that the new direction which is to be adopted will result in more affordable, more accessible, more attainable and more effective health care.

> *But nothing will change unless or until those who control resources have the wisdom to venture off the beaten path of exclusive reliance on biomedicine as the only approach to health care ... In a free society, outcome will depend on those who have the courage to try new paths and the wisdom to provide the necessary support* (Engel 1977:135).

NOTES

1. For the purposes of African traditional medicine, the WHO definition of traditional medicine has been somewhat modified by omitting the qualification "written transmission" from this definition.
2. In a report in the *Vrye Weekblad* of 20 March 1990 it was alleged that the Civil Co-operation Bureau (CCB) financed the establishment of the SATHC, so that traditional healers could infiltrate communities and make propaganda for the government. The establishment of the traditional healers' organization ANHA (currently Traditional Medical Practitioners Association) is a direct result of dissatisfaction with the SATHC.
3. A black city approximately 60 km from Bloemfontein.
4. Illness or misfortune is ascribed to the active, deliberate intervention of an agent, which may be human (witch/sorcerer), non-human (ancestral spirits), or supernatural (a deity/other powerful being).

REFERENCES

AAKSTER CW 1986. Concepts in alternative medicine. *Social Science and Medicine* 22:265-273.

ADEMUWAGUN ZA 1979. Problem and prospect of legitimatizing and integrating aspects of traditional health care systems and methods with modern medical therapy: the Igbo Ora experience. In: Ademuwagun ZA *et al. African therapeutic systems*. Waltham, Massachusetts: Crossroads Press. Pp. 158-164.

ADEMUWAGUN ZA *et al.* 1979. *African therapeutic systems*. Waltham, Massachusetts: Crossroads Press.

AKERELE O 1987. The best of both worlds: bringing traditional medicine up to date. *Social Science and Medicine* 24(2):177-181.

ANYINAM C 1987. Availability, accessibility, acceptability, and adaptability: four attributes of African ethno-medicine. *Social Science and Medicine* 25(7):803-811.

BANNERMAN RH, BURTON J & WEN-CHIEH C (eds). 1983. *Traditional medicine and health care coverage: a reader for health administrators and practitioners*. Geneva: World Health Organization.

BENNETT FJ 1986. Health revolution in Africa? *Social Science and Medicine* 22(7):737-740.

CAVENDER T 1988. The professionalization of traditional medicine in Zimbabwe. *Human Organization* 47(3):251-254.

CENTRE FOR HEALTH POLICY 1991. *Traditional healers in health care in South Africa: A proposal*. Johannesburg: Centre for Health Policy, (University of the Witwatersrand).

CHAVUNDUKA GL & LAST M 1986. African medical professions today. In: Last M & Chavunduka GL (eds). *The professionalisation of African medicine*. Manchester: Manchester University Press. Pp. 259-269.

COE RM 1978. *Sociology of medicine*. 2nd ed. New York: McGraw-Hill.

COMMUNITY HEALTH IN SOUTHERN AFRICA 1992. *Sangomas a powerful force in AIDS battle*. May/June:23.

DAWSON GR 1989. Human Resources Development Co-ordinator, South African Traditional Healers Council (personal interview, 25 April).

DE BEER FE 1979. *Meerdoelige opname onder swartes in stedelike gebiede, 1978 - besoeke aan toordokters*. Pretoria: HSRC.

DE VOS TJ DE V 1989-1990. Institute for Social and Economic Research, University of the Orange Free State (personal interviews).

EDITORIAL 1976. Herbalists, diviners and even witchdoctors. *South African Medical Journal* 50(19):721.

EDITORIAL 1982. Doctors and healers. *South African Medical Journal* 61(1):1.

ELLING RH 1981. Political economy, cultural hegemony, and mixes of traditional and modern medicine. *Social Science and Medicine* 15(A):89-99.

ELLIOT J 1984. Black medical students and African cosmological beliefs. *Africa Insight* 14(2):109-112.

ELOFF CC 1988. Beplanning van navorsing. *Research Bulletin* 18(4):1-6.

ENGEL GL 1977. The need for a new medical model: a challenge for biomedicine. *Science* 196(4286):129-135.

FARRAND D 1984. Is a combined Western and traditional health service for black patients desirable? *South African Medical Journal* 66(20):779-782.

FIELD MG 1976. Comparative sociological perspectives on health systems: notes on a conceptual approach. In: Kleinman AM *et al.* (eds). *Medicine in Chinese subcultures: comparative studies of health care in Chinese and other societies.* Washington DC: US Government Printing Office. Pp. 567-587.

FOSTER GM 1983. An introduction to ethnomedicine. In: Bannerman RH *et al.* (eds). *Traditional medicine and health care coverage: A reader for health administrators and practitioners.* Geneva: World Health Organization. Pp. 17-24.

FREEMAN M 1992. Negotiating the future of traditional healers in SA - differences and difficulties. *Critical Health* 40:64-69.

GESCHIERE P & VAN WETERING W 1989. Zwarte magie in een onttoverde wereld. *Sociologische Gids* 36(3-4):150-154.

GLASSER M 1988. Accountability of anthropologists, indigenous healers and their governments: a plea for reasonable medicine. *Social Science and Medicine* 27(12):1461-1464.

GOOD CM *et al.* 1979. The interface of dual systems of health care in the developing world: toward health policy initiatives in Africa. *Social Science and Medicine* 13(D):141-154.

GREEN EC 1988. Can collaborative programs between biomedical and African indigenous health practitioners succeed? *Social Science and Medicine* 27(11):1125-1130.

GREEN EC & MAKHUBU L 1984. Traditional healers in Swaziland: toward improved co-operation between the traditional and modern health sectors. *Social Science and Medicine* 18(12):1071-1079.

HARRISON IE 1979. Traditional healers: a neglected source of health manpower. In: Ademuwagun ZA *et al. African therapeutic systems.* Waltham, Massachusetts: Crossroads Press. Pp. 197-201.

HERBST D & BRITZ PDS 1986. *Die toordokter as personeelkonsultant: 'n gevallestudie.* Pretoria: HSRC.

HOLDSTOCK TL 1979. Indigenous healing in South Africa: a neglected potential. *South African Journal of Psychology* 9(3/4):118-124.

JANSEN FE 1983. The medical system as an aspect of culture and some acculturative effects of Western cross-cultural medical services. *South African Journal of Ethnology* 6(1):11-17.

KARLSSON EL & MOLOANTOA KEM 1984. The traditional healer in primary health care: yes or no? *South African Journal of Continuing Medical Education* 2:43-47.

KLEINMAN AM, KUNSTADTER P, ALEXANDER ER & GALE JL (eds). 1976. *Medicine in Chinese subcultures: comparative studies of health care in Chinese and other societies.* Washington DC: US Government Printing Office.

KOUMARÉ M 1983. Traditional medicine and psychiatry in Africa. In: Bannerman RH *et al.* (eds). *Traditional medicine and health care coverage: A reader for health administrators and practitioners.* Geneva: World Health Organization. Pp. 25-32.

KRIEL JR & BEUSTER DJ 1977. Health and health care systems. *South African Medical Journal* 5 February:167-168.

LAST M 1986. Introduction - The professionalisation of African medicine: ambiguities and definitions. In: Last M & Chavunduka GL (eds). *The professionalisation of African medicine.* Manchester: Manchester University Press. Pp. 1-19.

LAST M & CHAVUNDUKA GL (eds) 1986. *The professionalisation of African medicine.* Manchester: Manchester University Press.

MacCORMACK C 1986. The articulation of Western and traditional systems of health care. In: Last M & Chavunduka GL (eds). *The professionalisation of African medicine.* Manchester: Manchester University Press. Pp. 151-162.

MACLEAN U & BANNERMAN RH 1982. Utilization of indigenous healers in national health delivery systems. *Social Science and Medicine* 16:1815-1816.

MANKAZANA EM 1979. A case for the traditional healer in South Africa. *South African Medical Journal* 56(23):1003-1007.

McCALL GJ & SIMMONS JL (eds) 1969. *Issues in participant observation: a text and reader.* Reading, Massachusetts: Addison-Wesley.

METELERKAMP P 1993. Bossies, blare "genees" swartes ... *Insig,* Mei 1993:20-21.

MILLER N & ROCKWELL RC (eds) 1988. *AIDS in Africa. The social and policy impact.* Lewiston/ Queenston: Edwin Mellen Press.

MKWANAZI I 1987. *Witchcraft and modern surgery.* Paper delivered at the South African Nursing Congress, Bloemfontein, July:24-45.

MORRIS B 1986. Herbalism and divination in Southern Malawi. *Social Science and Medicine* 23(4):367-377.

NEUMANN AK & LAURO P 1982. Ethnomedicine and biomedicine linking. *Social Science and Medicine* 16:1817-1824.

NGUBANE H 1981. Aspects of clinical practice and traditional organization of indigenous healers in South Africa. *Social Science and Medicine* 15B(3):361-365.

OPPONG ACK 1989. Healers in transition. *Social Science and Medicine* 28(6):605-612.

OYEBOLA DDO 1986. National medical policies in Nigeria. In: Last M & Chavunduka GL (eds). *The professionalisation of African medicine.* Manchester: Manchester University Press. Pp. 222-236.

PEARCE T 1986. Professional interests and the creation of medical knowledge in Nigeria. In: Last M & Chavunduka GL (eds). *The professionalisation of African medicine.* Manchester: Manchester University Press. Pp. 237-258.

PEDERSEN D & BARUFFATI V 1989. Healers, deities, saints and doctors: elements for the analysis of medical systems. *Social Science and Medicine* 29(4):487-496.

PRESS I 1980. Problems in the definition and classification of medical systems. *Social Science and Medicine* 14(B):45-57.

PRETORIUS E 1984. Die medisyne en samelewingskritiek. 'n Analise van die medikaliseringsliteratuur. Fokus op die Sosiologie. *Acta Academica (new series)* B:34-49.

RAKOLOTA T 1990. Director, African National Healers Association (personal interview 21 May).

RAMANOHISOA C 1983. The African Region. In: Bannerman RH *et al.* (eds). *Traditional medicine and health care coverage: A reader for health administrators and practitioners.* Geneva: World Health Organization. Pp. 209-221.

RAPPAPORT H 1980. The integration of scientific and traditional healing: the problem of demystification. In: Ulin PR & Segall MH (eds). *Traditional health care delivery in contemporary Africa.* Syracuse University, New York: Maxwell School of Citizenship and Public Affairs. Pp. 81-98.

REPUBLIC OF SOUTH AFRICA. *Wet op Onderdrukking van Toorkuns, Wet 3 van 1957,* soos gewysig in *Wysigingswet op Onderdrukking van Toorkuns, Wet 50 van 1970.* Pretoria: Government Printer.

SAVAGE MTD 1986. Health. *RSA 2000* 8(1):59-67.

SCHATZMAN L & STRAUSS AL 1973. *Field research.* Englewood Cliffs, New Jersey: Prentice-Hall.

SCHMIDT JJ 1976. *Determining westernization/traditionalism among blacks:a methodological contribution.* Pretoria: HSRC.

SCHURINK EM 1986. Die metodologie van ongestruktureerde onderhoudvoering. *Research Bulletin* 16(3):43-53.

SIMONS HJ 1957. *Traditional healing: new science or new colonialism?* (Essays in critique of medical anthropology.) Owerri: Conch Magazine Limited.

SLIKKERVEER LJ 1982. Rural health development in Ethiopia: problems of utilization of traditional healers. *Social Science and Medicine* 16:1859-1872.

SOUTH AFRICA (REPUBLIC). CENTRAL STATISTICAL SERVICE 1981. *Population census 1980.* Pretoria: Government Printer.

SOUTH AFRICA (REPUBLIC). CENTRAL STATISTICAL SERVICE 1986. *Population census 1985.* Pretoria: Government Printer.

SPRING A 1980. Traditional and biomedical health care systems in Northwest Zambia: a case study of the Luvale. In: Ulin PR & Segall MH (eds). *Traditional health care delivery in contemporary Africa.* Syracuse University, New York: Maxwell School of Citizenship and Public Affairs. Pp. 58-79.

STAUGARD F 1986. Traditional health care in Botswana. In: Last M & Chavunduka GL (eds). *The professionalisation of African Medicine.* Manchester: Manchester University Press. Pp. 51-86.

STEPAN J 1983. Legal aspects. In: Bannerman RH, *et al.* (eds). *Traditional medicine and health care coverage: A reader for health administrators and practitioners.* Geneva: World Health Organization. Pp. 290-313.

SUID-AFRIKAANSE OORSIG. 1987. *'n Paar gelowe oor tradisionele medisyne en geneesmiddels.* 13 February:2.

SUNDAY TRIBUNE. 1988. *Sangomas, practitioners of ethnic mumbo-jumbo or "shrinks in animal skins"?* 7 August:15.

ULIN PR 1980. Introduction - Traditional healers and primary health care in Africa. In: Ulin PR & Segall MH (eds). *Traditional health care delivery in contemporary Africa.* Syracuse University, New York: Maxwell School of Citizenship and Public Affairs. Pp. 1-11.

ULIN PR & SEGALL MH (eds). 1980. *Traditional health care delivery in contemporary Africa.* Syracuse University, New York: Maxwell School of Citizenship and Public Affairs.

VAN DER MERWE RB 1990. Institute for Social and Demographic Research, University of the Orange Free State (personal interview).

VENTER JC 1988. Nursing Service Manager, Botshabelo Hospital (personal interview 27 September).

VIDICH AJ 1969. Participant observation and the collection and interpretation of data. In: McCall GJ & Simmons JL (eds). *Issues in participant observation: a text and reader.* Reading, Massachusetts: Addison-Wesley. Pp. 78-89.

VRYE WEEKBLAD. 1989. *Dolosgooiers, toordokters of magiese genesers.* 19 May:10-11.

VRYE WEEKBLAD. 1990. *Die BSB en die toordokters ...* 20 March:1-2.

WALKER R (ed.) 1985. *Applied qualitative research.* Aldershot, England: Gower Publishing Company.

WARREN DM *et al.* 1982. Ghanaian national policy toward indigenous healers. *Social Science and Medicine* 16:1873-1881.

WATTS HL 1980. Some reactions to illness of urban black and Indian families in Durban. *South African Medical Journal* 12 April:589-592.

WIERENGA J 1988. Tradisionele geneser: kwak of heler? *De Kat* September:50-53.

WORLD HEALTH ORGANIZATION (WHO) 1978. *The promotion and development of traditional medicine.* Technical Report Series 622. Geneva: WHO.

YODER PS 1982a. Biomedical and ethnomedical practice in rural Zaïre: contrasts and complements. *Social Science and Medicine* 16:1851-1857.

YODER PS (ed.) 1982b. *African health and healing systems: proceedings of a symposium.* Los Angeles, California: Cross Roads.

YOUNG A 1983. The relevance of traditional medical cultures to modern primary health care. *Social Science and Medicine* 17(16):1205-1211.

BRN: 403390

ORDER: 93.2185

COPY: PB 93659

R 41.00