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TRADITIONAL AND MODERN MEDICINE IN SOUTH AFRICA: A RESEARCH STUDY*

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Abstract—This paper examines the relationship between traditional and modern medicine with reference to an experimental research study conducted in South Africa, which focused on interviews by traditional Zulu healers and modern clinical psychologists with the same group of psychiatric patients Results indicated that while traditional and modern practitioners worked from different theoretical orientations, they were in significant agreement as to both diagnosis and treatment of patients when faced with the same limited choice of options. Furthermore, patients perceived both traditional and modern practitioners as being more or less equally helpful. Results are compared with those of other studies Local and international implications for the relationship between traditional and modern medicine are discussed.

Key words—traditional/modern medicine, South Africa

INTRODUCTION

At the *Ninth International Conference on the Social Sciences and Medicine* held in Finland, 8–12 July 1985, the ongoing global, dynamic interplay between modern and traditional medicine, was again a focus of attention The distinction between 'modern' and 'traditional' medicine is, of course, absolutely arbitrary when one considers the personal, interpersonal and community variables affecting the interchange between healers and patients within the total healing context It is, however, a useful, generally-accepted distinction broadly denoting modern, Western-orientated, biomedical, structurally dominant system in contrast to more local, culturally relativistic, humoral, functionally strong, traditional healing approaches respectively [1, 2]

While on the surface there may seem great variation in traditional medicine practised in South Africa (in keeping with its many varied people and communities), core universal components exist which are shared by many peoples across the globe, e.g. supernatural magical and religious practices, traditional diviners and herbalists [3, 4]. Traditional medicine is most commonly practised in rural areas lacking in modern health care facilities. Modern medicine is increasingly accepted as the treatment of choice by most, although eclectically chosen combinations of modern and traditional medicine remain common [5–7]. This trend, commonly observed in Africa, has been partly attributed to the relative differential emphasis of the two systems on content and cause or "what and why of illness and health respectively" [8, 9]. In South Africa, as in other African countries, the issue of integration/co-operation between traditional and modern medicine is an ongoing one. Modern mental health professionals and those most committed to a modern bio-psycho-socio-cultural approach and primary health care in particular, have urgently called for greater integration [10–18]

One of the most essential basic distinctions noted between modern and traditional medicine is their relative natural vs supernatural orientation respectively. This is understandable in view of the historical foundations on which each is based, i e the model of natural science with its strong empirical traditions vs traditional religious theories of illness and shamanistic magic ritual [3, 5, 8, 17]

Whereas the architypal shaman is an all-in-one type of healer, modernization has resulted in increasingly role specialized traditional healers. Broad non-mutually exclusive categories of traditional healers can still be made. A good case can be made for there being three main types of indigenous Zulu healers, i.e. the traditional doctor (*inyanga*) who is usually male and specializes in herbal medicine, the diviner (*isangoma*) who is traditionally female and operates within a traditional religious supernatural context as accepted medium with the ancestral shades and the faith healer (*umthandazi*) [19]. The advent of the *umthandazi* or *umprofethi*, faith healer/prophet is an interesting phenomenon which can be traced to the rise of the African undependent church movement, which broke away from the more Western oriented missionary churches. It has been argued that many of the traditional priest/diviner/psychodiagnostician/cultural healer roles of the *insangoma* have been taken over by the *umthandazi* within a modern supernatural religious, e.g. Christian framework and urban setting [20–23].

The role of the interview as a diagnostic and therapeutic procedure has time-honoured traditions in both modern and traditional medicine. It is in the context of the initial interview that differences between traditional and modern practitioners become particularly apparent [24] Owing to training in the secular, empirical tradition of modern medicine with its disease orientated approach and operationally defined diagnostic nosologies (e.g. the DSM III of the American Psychiatric Association), the modern men-

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tal health professional, for example, typically takes great care in asking detailed questions concerning mental status and symptom content of the disorder Feedback to the patient is secondary, being dependent on the differential diagnosis The traditional diviner, on the other hand is the recognized authority on the cosmic supernatural world and accepted medium with the ancestral shades. The diviner is thus consulted with the specific contractual expectation that the *cause* of illness will be divined The *vumisa* technique of the *isangoma*, for example, consequently typically consists of the healer telling the patient of the problems and honing in on specific areas by assessing the degree of expressed agreement by the patient and family relatives.

AIM

The general aim of this paper is to explore further the relationship between traditional and modern medicine with specific reference to research conducted in South Africa [26] by the author and co-workers at the University of Zululand, Psychology Department. The specific aim of this research was to compare interviewing, assessment and treatment planning procedures of traditional and modern practitioners.

METHOD

Subjects

There were three groups of subjects as follows: 3 traditional healers who had unequivocably classified themselves as an *inyanga*, *isangoma* and *umthandazi*, coded A, B and C respectively; 3 registered clinical psychologists, members of the Psychology Department Staff, coded D, E and F; 3 psychiatric patients, coded G, H and I from the local hospital psychiatric outpatient clinic, who had volunteered to take part in the experiment, after approval had been obtained from the local health department.

Apparatus

Two one-way rooms with videotape facilities

Procedure

The 6 therapists (3 healers and 3 psychologists) were given the following standardized instructions (translated into Zulu for the healers) before interviewing patients:

"You are to interview psychiatric patients from Ngwelezane Hospital for approximately 45 minutes Use any interview method you like, for example, the one to which you are accustomed Your interview will be videotaped Following the interview you will be asked standardised questions about symptomatology, etiology, diagnosis, treatment and prognosis of the patient"

In a randomized experimental design over 3 days, therapists were each allowed a 45 minute interview with each patient, one interview per day. Following the interview, experimenters administered a standardized questionnaire to the therapists, as indicated above. Thereafter, therapists were required to rank order various standardized diagnostic and treatment possibilities chosen prior to the experiment for their relative conceptual orthogonality and the fact that connotationally equivalent terms (as agreed on by independent raters) existed in the Zulu language Diagnostic categories were anxiety, culture bound disorder, depression, epilepsy, mental retardation, physical disorder of natural causation and schizophrenia Treatment categories were biological, psychological, sociocultural and religious orientated treatment components. After the patients had been interviewed by all six therapists they were asked to rank order the therapists in terms of helpfulness Patients and healers were remunerated financially for their involvement in the research.

RESULTS

Table 1 refers to the 6 therapists views on symptomatology, etiology, diagnosis and treatment when interview data recorded from these 4 categories were classified by independent raters as either natural or supernatural in content orientation This natural/supernatural (*umkhuhlane/Ukufa kwabantu*) classification was based on a well established distinction noted by various authors [3, 5, 7, 17]. Chi-square analysis using Yates correction for small numbers [27, p 87] confirmed that healers differed significantly from psychologists in their relative emphases on natural and supernatural interviewing orientations ($\chi^2 = 22\ 88$, $P < 0\ 001$)

In practice, psychologists typically used question and answer psychiatric interviewing techniques, taking a case history, mental status examination etc., whereas healers emphasized both natural methods as above, as well as supernatural, e.g. divination through bone throwing after invoking ancestral blessing or following prayer.

Table 2 refers to Kendall's coefficients of concordance and levels of confidence (in brackets) for the 6 therapists ranking of the 7 diagnostic and 4 treatment choices. As indicated significant agreement was reached by healers and psychologists with regard to choice of diagnosis and treatment for each patient for each patient.

Table 3 refers to the patients' ranking of the 6 therapists in terms of helpfulness. No significant agreement was reached by the patients (Kendall's coefficient of concordance, $W = 0\ 008$) which probably reflects individual patients' tastes Simple summation of the rankings achieved by the healers and psychologists (33.30 respectively) indicated that both groups were viewed by the patients as being more or less equally helpful.

DISCUSSION

The findings of this study provide confirmation and extension of those of earlier studies Traditional and modern practitioners were again found to work from different theoretical orientations [8, 28]. The significant degree of agreement, however, concerning both diagnosis and treatment when faced with the same limited choice implies some common perception by the interviewers of the patients' problems and needs This is to be expected, when it is considered that the same subjects were being interviewed and similar behaviour and phenomena observed. Furthermore it is instructive that both groups of traditional

Table 1 Interview orientations

Patients	Interview orientation	Therapists: Healers A	B	C	Psychologists D	E	F
G	Natural	3	4	1	4	4	4
	Supernatural	1	0	3	0	0	0
H	Natural	1	3	1	4	4	4
	Supernatural	3	1	3	0	0	0
I	Natural	1	3	2	4	2	4
	Supernatural	3	1	2	0	0	0

Table 2 Diagnostic and treatment choices

Patient	Diagnostic choices	Treatment choices
G	0 46 ($P < 0$ 01)	0 68 ($P < 0$ 01)
H	0 67 ($P < 0$ 01)	0 60 ($P < 0$ 01)
I	0 5 ($P < 0$ 01)	0 5 ($P < 0$ 01)

Table 3 Therapist helpfulness

Therapist	Patient G	H	I	Total
A	5	3	1	9
B	4	4	3	11
C	6	5	2	13
D	1	1	4	6
E	2	2	6	10
F	3	6	5	14

and modern practitioners, respectively, were seen as being more or less equally helpful by the patients. This finding again reemphasizes the earlier noted eclectic embrace by many of both traditional and modern medicine and earlier studies indicating both internal consistency and coherence of traditional Zulu approaches to illness and healing [3, 5, 6, 17]. Also various writers have noted universal components of psychotherapy shared by both traditional healers and modern health professionals [28–31].

The prospects for integrating modern and traditional medicine in various African countries have been a much debated topic over the past decade. Organizations such as the World Health Organization (WHO) have suggested re-training of traditional practitioners to serve as primary health care workers. There has been little empirical research on the implications of integration and the problems involved however These problems are of more than academic interest in such countries as Nigeria where the ratio of modern physicians to population is 1 22,000 way below the WHO goal of 1·10,000 for developing countries, and where partial integration of the two health systems has occurred [32–34].

In 1974, The South African Medical and Dental Council made official their rejection of indigenous healers in a Health Act which forbade non-registered healers to practise or perform any act pertaining to the medical profession. Registered healers were also forbidden to work in collaboration with non-registered healers. The unofficial view however, appears to differ from the official one. The *South African Medical Journal* (1976) which is the official organ of the Medical Association of South Africa, a professional and non-statutory organization, opposed the rejection of healers in its suggestion that medical professionals attempt to understand the healers' system of operation, accept healers in certain fields and help them to recognize those illnesses they are unable to cure [35, 36]. The above should not be taken as construing that healers are unprotected or uncontrolled by law, as provision was made for their practice in the Code of Zulu Law for example. Also more recently with the Associated Health Service Professions Act (No. 63 of 1982) the Council of Associated Health Professions, a separate statutory body not affiliated to the Medical and Dental Council, has provided for the registration and control of healers

Modern mental health medical and paramedical professionals in particular have urged for more integration of traditional and modern medicine with the view that indigenous healers have an important role to play, particularly in the fields of psychology and psychiatry [8, 33, 34] As indicated previously, shortcomings in the prevailing South African mental health services have been pointed out by various prominent South African psychiatrists and psychologists, who have appealed that greater recognition be given to and greater use made of the skills of indigenous healers in treating persons who may benefit from their services [10–18]. A two way model of referral to modern physician for curative treatment followed by indigenous healer for cultural explanations as to cause of illness has been suggested [8, 9]

In view of the relatively widespread usage of traditional medicine either alone or in combination with modern medicine, in principle and in theory the findings of the present research support greater integration of traditional and modern medicine. This remains a potentially contentious issue within the total South African political, economic, legal, administrative and health situation, with its many different communities varying in culture, language, modernization, education and government allocated health resources.

Continuing ongoing (perhaps nationally coordinated) research focusing on traditional and modern medicine is needed in South Africa along the lines undertaken in neighbouring Swaziland and Zimbabwe, with their greater need owing to relative lack of modern medical facilities [37, 38] Such research should particularly concern those medical, academic and research institutions and departments were practical rapproachment and co-operation between traditional and modern medicine is already effected and where both approaches are taught

The following are some of the areas that need to be investigated:

(a) Research with large representative groups of patients, traditional healers and modern practitioners

assessing the demand for as well as the opinions, problems and implications of greater integration of traditional and modern medicine This research would have to cover definition of terms, variations of traditional belief systems, the cultural integration of illness, ethical and legal implications of traditional and modern healers working together, training of traditional and modern healers, etc.

(b) Research focusing on the effect of modernization, education, economic, socio-cultural and political change on traditional and transitional societies and their related help-seeking behaviour and health practices

It is interesting to note, in the context, the extent to which accelerated modernization, urbanization and socio-political change has resulted in the roles of the traditional healers in South Africa becoming increasingly specialized and differentiated, with the *umthandazi* or faith healer receiving increasing popularity, particularly in urban areas

Wither thus process leads, in the meantime much can be gained both locally and internationally by continuing health education for and amongst both traditional healers and modern health care workers by regional educational and health institutions, with the goal of enlightened communication and recognition of both expertise and limitations in both systems by both systems

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