


# The historical relationship between African indigenous healing practices and Western-orientated biomedicine in South Africa: A challenge to collaboration

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South African traditional medicine is based on centuries-old cultural heritage, yet it remains popular today, used by a significant percentage of the population. It has adapted to changing times, endured persecution by unfriendly governments and now enjoys a new status with the government's adoption of the *Traditional Health Practitioners Act* 35 of 2004. The adoption of this act was an important first step by the national government towards the integration of traditional and Western health systems in official health services. However, many challenges still need to be addressed. Competition between traditional healers in Keiskammahoek has resulted in low participation in local traditional healers' councils, posing a significant challenge to future cooperative efforts between traditional healers and biomedical practitioners. Although biomedical practitioners have expressed mixed views on collaboration with traditional healers, exposure to traditional healers on a professional level, together with an understanding of traditional medicine theory, helps to foster an understanding and willingness to work with traditional healers. This article discusses the ways in which political consciousness and social dialogues have strongly influenced the relationships between different healthcare systems in South Africa, as well as the continuing challenges of healthcare delivery in the Eastern Cape.

**Contribution:** This article hopes to expand the long-debated call to integrate African indigenous medicine into the mainstream medical practice that continues to favour biomedicine to the detriment of local practices of medicine and healthcare.

**Keywords:** South African traditional medicine; rural communities; Eastern Cape; biomedicine; biomedical practitioners; traditional healers; collaboration; cooperation; integration.

## Introduction

M.D. (medical doctor): I quite agree with you as to the value of the rain, but you cannot charm the clouds by medicines. You wait till you see the clouds come, then you use your medicines, and take the credit which belongs to God only.

R.D. (rain doctor): I use my medicines and you employ yours; we are both doctors, and doctors are not deceivers. You give a patient medicines. Sometimes God is pleased to heal him by means of your medicine; sometimes not – he dies. When he is cured, you take the credit of what God does. I do the same. Sometimes God grants us rain, sometimes not. When he does, we take the credit of the charm. When a patient dies, you do not give up trust in your medicine, neither do I when rain fails. If you wish me to leave off my medicines, why continue your own? (David Livingstone in 'Conversations on Rain-Making' 1997:299)

Historically, South African traditional medicine is based on centuries-old cultural heritage, yet it remains popular today, used by an estimated 80% of the population (Baleta 1998:554). It has adapted to changing times, endured persecution by unfriendly governments and currently enjoys a new status in government with the recent adoption of the *Traditional Health Practitioners Act* 35 of 2004 (Republic of South Africa 2004:s.6, ss. 1). Since the proposal of the Traditional Health Practitioners Bill in Parliament in 2003 (Republic of South Africa 2005:s. 6, ss. 1), the integration of traditional medicine into existing official health services has become a legislative reality, hailed as a success by some and a travesty by others. Controversy over this monumental legislation has prompted biomedical doctors and other opposition parties to voice their concerns, whereas traditional healers and other proponents have praised the initiative and offered critiques as well. The controversial nature of the act has influenced collected works written on the topic of the integration of the different but related health systems in South Africa, exposing biases and leaving many questions unanswered as each side vies to prove the validity of its claims.

**Note:** Special Collection entitled Social Memory Studies, sub-edited by Christina Landman (UNISA) and Sekgothe Mokgoatšana (UL).

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Many researchers are quick to point out the historical relationship between traditional healers and missionaries, noting the change that occurred when colonial governments institutionalised healthcare in Africa. Muller and Steyn (1999:30) comment in their article on the culture and the feasibility of a partnership between Westernised medical practitioners and traditional healers that 'these [early] westernized healers were well aware of the limitations of Western medical science'. The example of Henry Callaway, a missionary and medical doctor who exchanged information with the Nguni traditional healers and viewed their health system in the context of the Nguni worldview, is given as support to their argument. The homepage of the African Christianity website, in describing the history of missionaries in sub-Saharan Africa, explains the shift in the relationship between Western doctors and traditional healers as the result of the creation of Western medical facilities (African Christianity n.d.):

[A]s the twentieth century progressed, missions began to specialize. Missionary doctors and nurses set up hospitals and clinics, but did not really spend much time curing the souls of their patients.

## The historical relationship between traditional medicine and Western medicine

Historically, traditional medicine existed in South Africa long before the Dutch arrived in the 17th century. Its relationship with Western medicine has not always been antagonistic, as the missionaries from Europe and the early doctors recognised the wisdom of traditional healers, whose medicines could cure the African diseases that the foreigners had never encountered (African Christianity n.d.):

[N]ineteenth century missionaries had spent a great deal of time and energy serving as medical practitioners, often with little or no formal training. Their healing arts were seen as part and parcel of the gospel they were bringing, whether they were conscious of it or not.

Even the missionaries who were trained as doctors recognised the value of the traditional remedies. For example, Henry Callaway, a missionary and medical doctor, exchanged information with Nguni traditional healers and viewed their health system from the context of the Nguni worldview: 'These westernised healers were well aware of the limitations of Western medical science' (Muller & Steyn 1999:30). When Western medical professionals arrived in Africa, they introduced two approaches to medical practice, namely, 'colonial [imperial] medicine as a governmental organisation of medical care and missionary medicine as initiated by missionary societies and churches' (Jansen 1997:344). In both approaches the same cultural model of medicine was promoted, the one in which students were trained in 'medical schools in Europe and North America' (Jansen 1997:344). The two types of health services were, however, as Jansen (1997:344) explained, inclusive of the 'aims they pursued, the motivation of their staff, and the comprehensive approach to medical mission work'. Jansen (1997:344) further elaborated

how the medical missions often 'sailed in convoy with the colonising powers. However, many examples exist of pioneering work by medical missions independent from colonial policy and support (Jansen 1997:344). The second half of the 19th century showed an increase in the medical missionary movement, as 'Western medicine gained momentum through a series of advances and discoveries' (Jansen 1997):

[A]s the twentieth century progressed, missions began to specialize. Missionary doctors and nurses set up hospitals and clinics, but did not really spend much time curing the souls of their patients. (p. 344)

Thereby they became more closely aligned to imperial medicine. Hammond-Tooke (1989) states that:

[O]ne of the main obstacles in assessing the possibility of co-operation between a healer in a Third World, small-scale society and a western medical practitioner is prejudice – in particular the notion that the traditional black beliefs and practices are the result of a 'primitive' or 'savage' thought process which is so different from that of 'modern society' that mutual understanding, let alone co-operation, is ruled out from the start. (p. 17)

Westernised medicine enjoyed much support from the colonial governments and also successive governments because this medicine was seen to be based on scientific and rational knowledge. Since the 18th century, Western society has prided itself on its rationality. The supreme example of rationality can be found in science, as 'science seeks to conquer nature, including the diseases that plague humankind' (Hammond-Tooke 1989:18).

In contrast, traditional healing was officially frowned upon and marginalised because it was perceived to be based on mystical and magical religious beliefs (Hopa, Simbayi & Du Toit 1998:8).<sup>1</sup> Work done by anthropologists such as Lucien Lévy-Bruhl at the beginning of the 20th century set forth a general theory of 'primitive mentality'. Lévy-Bruhl presented two major types of society – the primitive and the civilised – corresponding to the two opposed types of thought (Hammond-Tooke 1989:20).

## Integration of traditional and Western health systems: The case of the Eastern Cape

A case study was conducted in the village of Ngxalawe in Qoboqobo, a rural area of the former Ciskei homeland, to gain a perspective on the current state of cooperation between traditional healers and biomedical practitioners, patients' views on collaboration between traditional health practitioners and doctors, as well as perceptions of healthcare providers about the current state of collaboration.

1. It is worth noting here that a few centuries ago, medicine in Europe was 'a blend of art, science, myth, magic and superstition' (Truter 2007:58). It was not until the Renaissance that the process of rationalisation came about, affecting all aspects of society, including science and medicine. In 1543, Andreas Vesalius's *De Humani Corporis Fabrica* [On the Fabric of the Human Body] provided the foundation for human anatomy, announcing 'the Medical Renaissance which heralded the era of modern medicine'.

Key informant interviews, guided conversations and observation were used to gather necessary data. Key informant interviews at the Department of Health in Bisho provided information about traditional health policy formulation, implementation of policy and government structure. Background information about the area and demographic information were provided by government staff at the constituencies' office and the municipal office in the town of Keiskammahoek.

The adoption of the *Traditional Health Practitioners Act* 35 of 2004 was an important step by the national government towards the integration of traditional and Western health systems in official health services. However, many challenges still need to be faced. Competition between traditional healers in Keiskammahoek has resulted in low participation in local traditional healers' councils, posing a significant challenge to future cooperative efforts between traditional healers and biomedical practitioners. Also, although biomedical practitioners have expressed mixed views on collaboration with traditional healers, exposure to traditional healers on a professional level, together with an understanding of traditional medicine theory, helps to foster an understanding and willingness to work with traditional healers.

In defence of the civilised thoughts that colonial powers imported into Africa, the South African government has poured massive amounts of state and private resources into Western medicine at the expense of its traditional counterpart (Hopa et al. 1998:8). From as early as 1891, various pieces of legislation were passed prohibiting traditional healers from practising in colonial Natal. Amongst these are the *Witchcraft Suppression Act* 3 of 1957, the *Witchcraft Suppression Amendment Act* 50 of 1970 and the *Health Professions Act* 56 of 1974 (Richter 2003:8). The policy of apartheid further exacerbated this discrepancy with the creation of 'homelands' in the 1950s. Under a plan called 'Separate Development', the *Bantu Authorities Act* 68 of 1951 established 10 Bantustans (Free Glossary Online n.d.), designated to become independent states. In 1951, the Ciskei was established as one such 'independent republic' for Xhosa-speaking people in the Eastern Cape. In 1981, the Ciskei was granted 'independence', stripping away the right of South African citizenship to the citizens of the new territories. Homeland residents had little capital and few resource management skills and were subject to corrupt and abusive local governments (Hastings 1976; Homer-Dixon 1994:32; South African History Online n.d.). This resulted in a segregated health system whereby the white minority enjoyed amongst the best medical services available anywhere in the world, whereas the black majority and particularly those in rural areas were catered for by mostly Third World-quality health institutions that were characterised by poor facilities and inadequate resources (Hopa et al. 1998:8). Without adequate resources allotted to the development of Western medical services in the rural areas, particularly those in the homelands, the traditional culture, including the traditional health system, was able to remain intact.

## Globalisation of healthcare and 'alternative therapies' in South Africa

In a move to recognise the globalisation of healthcare, including non-Western therapies, the South African government formally recognised the popular use of 'alternative therapies' for medical care with the regulation of certain alternative medical professionals in the *Allied Health Professions Act* 63 of 1982 (1982:s. 31, ss. 1d). This act establishes registration, a licensing scheme and practice standards to regulate chiropractors, homeopaths, osteopaths and naturopaths, as well as ayurvedic practitioners. Traditional health practitioners were not addressed in this act.

### Qoboqobo experience (Keiskammahoek)

Keiskammahoek (its Xhosa name is Qoboqobo) is located about 42 km northwest of King William's Town in the Eastern Cape and consists of 37 villages (S. Zozi, SMS comm., 22 April 2005). Before 1994, this area belonged to the Ciskei homeland, and it was reincorporated into South Africa after the first democratic elections. The population of approximately 25 000 is predominantly Xhosa, but there are a number of townships where coloured people live, and there are also a few white people in the area. The main languages spoken are Xhosa and Afrikaans. Like much of the rural Eastern Cape, this area still bears the legacy of the separate development plan. It remains underdeveloped, with the majority of the people living in traditional mud houses. Unemployment rates are extremely high, and many people have to leave the area in pursuit of jobs. The inhabitants of this rural area suffer because of inadequate public works projects, for example, the provision of facilities such as running water, tarred roads and reliable electricity. Currently, most of the residents rely on collected rainwater, and 'the simplest rainfall knocks out the electricity' (P. Madlokazi [Constituency Office], pers. interview, 22 April 2005). A main tar road runs around the perimeter of all the villages, and the most popular forms of transportation are bakkies and buses. Few people own vehicles, limiting the availability of transportation, particularly at night.

### Qoboqobo official health services

In Keiskammahoek, there are nine permanent clinics, and there is also a mobile clinic that serves the areas that are far from the fixed clinics twice a month. Patients who do not use the mobile clinic must take a taxi (at a cost of R12 for a round trip) from Upper Zingcuka to the Gateway Clinic. Because even the Lower Zingcuka Clinic is far, many patients prefer to take a taxi to the Gateway Clinic. Located near Keiskammahoek, the Gateway Clinic is the busiest of the 10 clinics because it caters for all areas, including those that have access to other clinics. With a staff of 13 nurses and assistants, the clinic recorded almost 22 000 patient visits in the year 2004 alone. Its close proximity to the S.S. Gida Hospital makes for easy referral to the hospital, whereas clinics that are located farther away only refer emergency cases (for which an ambulance service is available). Non-emergency cases that require



consultation with a doctor must wait for the twice-monthly visits of Dr Gaynyana, who visits all the area clinics. Clinics are open from 08:00 to 16:00, Mondays to Fridays. After hours or on the weekends, patients must find their own transport to the hospital because the clinics are closed.

The S.S. Gida Hospital, the district hospital, offers outpatient as well as inpatient services to the community. In 2005 the hospital employed six doctors, 93 nurses (including professional nurses, enrolled nurses and nursing assistants) and six paramedical staff (including pharmacists, radiographers and auxiliary workers). For the period 2004–2005, the total bed occupancy was 28 845, and 10 994 outpatient visits were recorded (Mbebe Gqangeni [S.S. Gida Hospital], pers. interview, 22 April 2005).

There are also a number of traditional healers in the area. The overall number of traditional health practitioners has not been determined, but there are 57 qualified and certificated traditional healers.<sup>2</sup>

## Methodology

Key informant interviews, guided conversations and observation were the methods used for the purpose of this study. Because of the close proximity of the S.S. Gida Hospital to the village of Ngxalawe, all interviews with biomedical practitioners were conducted at the hospital and at the Gateway Clinic attached to it. Because these were the closest to Ngxalawe and were the most accessible healthcare institutions, data were not gathered at the eight other clinics in the area. For the purpose of standardising the data, a similar set of interview questions was used for interviewing both traditional healers and biomedical practitioners. Traditional healer nurses were asked questions similar to those asked in the interviews with traditional healers and biomedical practitioners. Key informant interviews were conducted with members of the health community, including traditional healers, nurses, doctors and patients. Additional interviews were conducted with Department of Health officials in Bisho to obtain information about traditional health policy, policy implementation and government structure. For background information and demographic information, Keiskammahoek government staff members were consulted in the offices of the municipality and the constituencies of Keiskammahoek.

Over a 3-week period, and with the assistance of available interpreters, 14 patients were interviewed in both English and Xhosa. Of these interviews, six were conducted during patient consultations with nurses at the Gateway Clinic; seven were conducted with the help of student nurses, who acted as interpreters in the tuberculosis ward (female A); and

2. This number was given to me by L. Ulana (pers. interview, 15 April 2005), the president of the local traditional healers' council. According to her, there are 10 qualified healers in Keiskammahoek Town and five qualified healers in Ngxalawe. It is not clear who issues the certificates to traditional healers, although Ms Ulana indicated that the magistrate's office tested sangomas who had completed their training and that these sangomas were accompanied by their trainers. Testing is done in a number of ways, including having the healers identify herbs and locate hidden items. 'If you can't pass the test, you are not a sangoma'.

one interview was conducted with a mother of a patient in the paediatrics ward, with a nurse acting as the interpreter. Of these patients, only two who were interviewed were male. During an interview with a patient, 13 short-answer questions were asked. The response rate was high, with only one interview left incomplete because of language barriers.

Key informant interviews with biomedical healthcare providers were conducted with four medical doctors, one pharmacist and six nurses (a total of 11). Because of time constraints, a questionnaire was administered in addition to conducting key informant interviews to obtain more responses. Questionnaires were distributed to five hospital staff members, and two were returned (a response rate of 40%). Both the returned questionnaires were completed by nurses.

Key informant interviews were conducted with various traditional healers. Five *iGqiras* in Keiskammahoek were consulted – four females and one male. The other healer who was interviewed considered himself to be a herbal practitioner, and he went to great lengths to distinguish himself from the traditional herbalists (*inyanga*). Despite his objections that he did not consider himself a traditional healer, his responses were combined with the responses of the other traditional healers. This decision was made in light of the *Traditional Health Practitioners Act*, under which he would be categorised as an 'herbalist'. A key informant interview was also conducted with the interpreter of an 'herbalist diviner' from Uganda, who owned a surgery in the town of Keiskammahoek. However, her responses were not recorded with the responses of the other interviewees' responses; the purpose of this specific interview was to obtain general information about herbalists.

## Perceptions of integration

Most healthcare practitioners were aware of efforts by the national government to integrate traditional medicine into official healthcare services, and some were aware of the adoption of legislature (the *Traditional Health Practitioners Act* 35 of 2004 2005:3). Many practitioners, particularly traditional health practitioners, expressed strong opinions about integration. There were biomedical practitioners who were either in favour or against integration, but there were no general trends amongst hospital staff. A few remained neutral, as long as they felt it would not affect their practice. Xhosa nurses and non-Xhosa doctors differed in their opinions about integration, regardless of whether they had had personal experiences with traditional medicine. Traditional healers and traditional healer nurses were almost unanimously in support of collaboration, with the notable exception of the herbal practitioner (who did not want to be associated with traditional healers).

Surprisingly, patients were almost equally split (7/13 vs. 6/13) in support of *iGqiras* working with doctors to treat patients. Much like the Xhosa nurses, their support for the use of traditional medicine did not necessarily translate into support for integration. Some patients implied that the two types of medicine should not be used together and that a

patient should have the choice of which health system to use for treatment. The patients in favour of integration expressed support for collaboration in terms of the knowledge possessed exclusively by traditional healers and doctors. A female patient explained, '[i]f they are working together it is good because they are going to help each other (if the one doesn't know about the sickness, the other will)'. This illustrates the duality in the belief of the patients – they would use both biomedicine and traditional medicine as they felt necessary.

Perceptions of the time frame of integration varied. Some health practitioners did not anticipate integration to ever occur fully in the area because there was a general resistance to change. Others believed it would take a long time, whereas still others expressed a more optimistic view of integration efforts. This makes it difficult to really ascertain how long it will take for integration to be complete, if it is possible at all. With the current lack of organisation amongst traditional healers, it will be difficult to implement uniform changes in the health services that are provided to the community. Looking at the community as it exists, uncertainty about the possibility of collaboration is understandable. It should also be noted that the definition of integration may vary depending on the interpretation of the respondent. Some may view collaboration as cooperation, whereas others may not consider collaboration to be complete until *amaGqira neNyangi* are working in a clinical setting side by side with doctors.

### Views on the *Traditional Health Practitioners Act 35 of 2004*

The variety of the responses to the *Traditional Health Practitioners Act 35 of 2004* was consistent with the views expressed by healthcare professionals about integration. Some general comments (both negative and positive) were made, but the comments that deserve the most attention are the ones that questioned the effectiveness of policy to regulate traditional health practitioners. Registration was the aspect that most healthcare practitioners commented on because registration with the government represents the official recognition of traditional healers. Traditional health practitioners were generally optimistic about registration, feeling that it would legitimise their practice; certification would mean that the government recognised the individual as a 'real' *iGqira*. Doctors and nurses also addressed the issue of registration. They questioned how criteria would be developed to test *iGqiras* if no regulated training curriculum existed. This supported an important argument found in the literature about the regulation of traditional healers. The question is, if there is no set training curriculum for traditional healers, how can a regulating council determine what knowledge an *iGqira* or herbalist must possess?

### Challenges relating to integration in Keiskammahoek

One of the main challenges that will have to be overcome in the integration of traditional medicine and Western medicine in Keiskammahoek is the current lack of

organisation amongst traditional healers in the area. Although traditional healers are willing to collaborate with the biomedical healthcare providers, they do not share the same enthusiasm about cooperating with other traditional healers. The competition amongst traditional healers has resulted in the *amaGqira* working against each other in many cases, rather than uniting, following a common goal and working together through a local traditional healers' council. In Keiskammahoek, there are only 57 registered *amaGqira*, but there are likely to be many more who are practising without certification. Because people seek out traditional healers based on word-of-mouth testimonies by patients 'cured' by a specific *iGqira*, communities' demand for registration will be a powerful tool in encouraging *amaGqira* to register with the Interim Traditional Health Practitioners Council. However, it is not unlikely that the competition between *amaGqira* will also encourage registration, even if only to be officially recognised by the national government as a 'real' *iGqira*. Competition amongst *amaGqira* will ultimately make regulation of such practitioners difficult because of potential problems such as unwillingness to share information about medicines used and non-participation in organisations' activities. In order for regulation of traditional healers to be successful, support from all sides will be needed. Community members will have to insist on being treated by registered traditional healers, and registered traditional healers will have to learn to cooperate within the government structures that will be developed on the ground.

The biomedical health community in Keiskammahoek has demonstrated varied reactions to collaboration with traditional healers. This reflects the current lack of communication and collaboration between doctors and *amaGqira*. It appears that the biomedical practitioners who are most receptive to the idea of collaboration are those who have the most knowledge about the traditional health system and the cultural beliefs about health held by their patients. However, personal use of traditional medicine does not necessarily translate into support for integration of the two health systems. Those who have had exposure to traditional medicine on a professional level (such as through personal contact with *iGqiras* in a hospital setting or in their professional capacity, for example, when doing courses such as attending classes in pharmacy school) are most receptive to collaboration with traditional healers. This illustrates the importance of mutual understanding between biomedical practitioners and traditional health practitioners. Perhaps if a more comfortable relationship is established between medical doctors and traditional healers, the concerns of patients about integration will be allayed.

### Integration at national level

At the time of writing this article, the *Traditional Health Practitioners Act 35 of 2004* was the only piece of legislation passed on a national level recognising and regulating traditional healers. Because there currently exists no framework to regulate

traditional health practitioners at a ground level, there are a number of government structures that need to be developed in order to regulate traditional healers at any level of integration. The Interim Traditional Health Practitioners Council and the national government still have to determine what role traditional healers will play in official health services. A question that will have to be addressed is, should traditional medicine occupy a subordinate role within the existing medical profession structure, or should it be autonomous as an independent and new medical profession?<sup>3</sup> Multiple levels of collaboration are possible: cooperation (traditional healers act as supporters of directly observed treatment of tuberculosis to ensure patients' compliance to Western ways of treatment); traditional healers are recognised as primary care providers and are taught when to refer patients to medical doctors; at referral level, the establishment of a reciprocal referral system amongst biomedical and traditional healers; or a fully integrated system, such as in China, where medical schools teach traditional medicine and traditional healers work side by side with medical doctors in hospitals and clinics. How far collaboration will go has yet to be determined by the government, traditional healers and the biomedical community.

## Conclusion

With the adoption of the *Traditional Health Practitioners Act 35* of 2004, the South African national government took a monumental first step on the long road to integrating traditional health practitioners into a healthcare system that has historically been antagonistic to traditional medicine. This article has sought to contextualise the political consciousness and dialogues that influence healthcare systems and the tension between biomedical doctors and traditional healers. In taking this first step, South Africa joins numerous other developing nations as they seek to expand healthcare services to all their citizens whilst addressing the deepening constraints to healthcare delivery in South Africa.

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## Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

## Authors' contribution

P.M.G. and S.M. both contributed to the design and implementation of the research, analysis of the results and writing of the manuscript.

<sup>3</sup>This question was posed by Last (1986:3).

## Ethical consideration

This article followed all ethical standards for a research without direct contact with human or animal subjects.

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## Data availability statement

Data sharing is not applicable to this article, as no new data were created or analysed in this study.

## Disclaimer

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any affiliated agency of the authors.

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