Transferring Health Technology to South Africa: The Importance of Traditional African Culture

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ABSTRACT. The transfer of new health technology to South Africa is occurring despite the fact that North American and European health care planners and entrepreneurs have a very limited understanding of traditional Black South African cultures which condition the health-related behaviors of the majority of the population. Consequently, relatively few people of African descent in this very diverse nation are, at least initially, benefiting from the new imported medical technology. This study gives an overview of traditional Black medicine in South Africa and, through the presentation of several case studies, discusses its implications for the societal adoption of new health technology received from the United States and other industrialized nations. The example of the successful application of cervical cancer exams in rural and urban clinics of the Eastern Cape is analyzed and institutional mechanisms that support successful transfer are identified.

1. Introduction

With the end of Apartheid and the reopening of South Africa to United States and other international investment, the transfer of new drugs, medical techniques, and health care organization to the most developed economy in Africa has rapidly increased (Green, 1994). This transfer of health technology is occurring at a time when American and European health care planners and entrepreneurs have little or no understanding of Black South African cultures which profoundly influence the health related behaviors of the majority of the people living in this region (Sindiga, 1995). Consequently, relatively few people of African descent in this very diverse nation are, at least initially, receiving the benefits from the new medical technology that has been imported (Courtney, 1998).

The objective of this paper is to provide an overview of traditional Black medicine in South Africa and, through the presentation of several case studies, to discuss its implications for the societal adoption of new health technology received from western and other industrialized nations. The example of the successful application of cervical cancer exams in rural and urban clinics of the Eastern Cape is analyzed and institutional mechanisms that support successful transfer are identified.

2. Traditional vs. modern medicine

The contemporary debate in South Africa on "alternative" and "modern medicines" captures the differences between the proponents of modernity and those primarily African intellectuals who are disenchanted with modernist claims. The emphasis of modern medicines on treating the organic forms of illness is countered by the voices who argue for an African way and its insistence

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on the "holistic" treatment of the afflicted – a treatment that is also sensitive to the social, psychological, and spiritual parts of the human animal.

This debate has engendered at least two responses. One sees the two forms of medicine as antithetical where "traditional Black medicine" is seen as nothing but "voodoo science," and its practitioners as nothing but "misguided" or "lost" people. The other group sees the two forms of medicine not as opposed and antithetical forms but as "complementary." Some, among the latter group, have begun to compile registers of medicines which show when traditional medicines should be harvested, which part is useful for which cure, how much to use for which illnesses, and how often to use it. And as the critique of Eurocentricism is increasing, so does the latter seem to be the more authentic, indigenous African way. It becomes another example of alternative forms of knowledge that, from a perspective outside modernity, should be included in the canon of science as both valuable and effective.

This paper maintains that an accurate understanding of the current role and influences of traditional Black medicine requires study of its historical evolution. Unless we investigate how "traditional medicine" survived in South Africa, especially in the nooks and crannies of urbanization under apartheid, we will be reaching empty conclusions. Although its practices survived and modern medicine failed to discredit them, we can hardly afford romantic versions of their existence. We need to ask, "How were they affected by the environment in which they led an illegitimate and sometimes illegal existence and yet were considered essential by the dispossessed?" How do we account for the power of these beliefs and how do we distinguish between traditional medical craft, health science, and charlatans' exploitation of people's anxieties? What are the implications of traditional medicine for the transfer of new medical technology?

An example of the tragic power of traditional medical beliefs and the role of "Afrocharlatans" would be the incidents which occurred near Kroonstad between late 1997 and early 1998: grieving relatives of 12 children killed in a minibus accident at Kroonstad on October 30 refused to let them be buried in the belief that they could be revived. Kroonstad police spokesman Capt. DeBeers reported that relatives were negotiating with local traditional healers to bring the children back to life (Scheepers, 1998).

The funeral was cancelled when relatives claimed that the coffins did not contain the bodies of their children, but images produced by *muti* (medicines). Relatives claimed that the bodies appeared to have long hair and long and shrunken faces like those of elderly people.

At the "cancelled" funeral, 3 women accused of being witches were chased and hacked to death. A local *sangoma* (witchdoctor) was forced to flee from the area fearing for his life when he realized that the families believed that the children could be revived and that he would not be able to convince them. Some days after the cancellation of the funeral, rumors spread that the *sangomas* had succeeded in bringing the children back to life. Another woman was stabbed to death on suspicion that she was bewitching the "reincarnated" children.

An attempt was made to bury the children on the 10th of December, but a group of people exhumed the coffins after the funeral and attempted to burn the coffins – only succeeding in burning two. The relatives managed to bury their dead the following day.

By late January 1998, a number of women were living in fear for their lives after having been told that their names were on the "hit list." Apparently, members of the community had consulted with *sangomas* and had been told that the children had been turned into zombies and were being kept in the witches' wardrobes. One woman, who wanted to clear her name, wanted members of the community to open her wardrobes to see for themselves. However, there were no takers. Besides, the *sangomas* had told the community that the zombies will only be visible to those detaining them (Scheepers, 1998).

3. Basic terms

"Traditional medicine" refers to those medicines used by healers which include plants (indigenous and otherwise), products of plants, sea water, animal parts, blood and emissions, and any mixture of such with either water or animal blood. When reference is made to "traditional" or

"African" medicine, in this context, it can never be African because of its chemical composition, genealogy, or even results. It is African because both the provider and the user tap into the inner crevices of African consciousness which are rooted in beliefs in African cosmology and cosmogony. The traditional healer, in turn, does not require formal education to master the "trade," he/she only needs training in African cosmogony and cosmology as well as training in the use of African medicines.

The advent of Christianity and its amalgamation with African beliefs resulted in the emergence of another set of "traditional healers" and medicines. Such medicines are referred to in Zulu as iziwasho (medicines for the purification of the physical and well as the spiritual body). These are either pure water that has been prayed over, ocean water, and water mixed with other substances while summoning the powers of the Christian spirits such as Jesu (Jesus) and Mariya (Jesus' mother), there are those who claim to have powers also to communicate with African spirits as well.

4. Reasons for the reliance on traditional medicine

The legal exclusion of Africans from state institutions fostered a reliance on unofficial, and often illegal, institutions and practices in order to have their needs met. Politically, economically, and socially barred from receiving quality service for all their ailments, Africans resorted to "other worldly" forms of intervention. Such interventions included African traditional practices and Christianity (in both its traditional and Africanized forms). All this helped to keep urban areas – much against the dictates of modernism – as environments which are "vastly enchanted" or heavily influenced by traditional beliefs.

The cultural exclusion of Africans rendered ordinary people unable to interact with the modern cultures and all their "promises." In addition, the townships in which Africans lived were, among other things, environments of poverty, crime and violence. To make it through the enchantments and the hardship of the urban environment, one needed interventions from more powerful "other-worldly" powers.

As more and more Africans sought relief in indigenous medicines and other combinations of African medicine and Christianity, an industry of sorts developed. Currently, the production and distribution of *muti* (traditional medicine) is a multi-million rand industry. There are an estimated 250,000 to 300,000 healers in the country – which by far outnumbers other health practitioners here: there are only 30,000 doctors and 200,000 nurses in South Africa. Proof of the quantities of muti used can be deduced from the results of a study done some years ago in KwaZulu-Natal. Some 150,000 plants, 2,000 reptiles, and 350kg of bark were traded in a week in the Durban area (Gray, 1998).

The added fact that many Africans who lived in urban areas did not know the secrets and authentic teachings of African medicine resulted in the development of an environment in which, among real traditional healers, charlatans could flourish and proliferate. The charlatan presents him or herself as someone who possesses powers that an ordinary medicine person does not possess. He or she can cure illnesses considered incurable and solve what seems to be inscrutable social and personal troubles and burdens (Comaroff, 1993).

The charlatans thrived, largely, due to the effects of the encounter of Africans with modernization. That encounter had produced urban people who needed "other worldly" interventions to pass at school, find employment, keep employment, find love, stay in love, find a marriage partner, maintain marriages, protect oneself from violence, protect one's property from theft, etc. Charlatans proliferate to such an extent that, in urban areas, one is more likely to use a charlatan than a real medicine man or woman for the treatment of an illness. The following case study illustrates the preference of many Black South Africans for traditional healers and the tragic consequences of depending upon a charlatan for the cure of a serious illness.

Mrs. Bisho's story

Mr. and Mrs. Bisho have been married for about 26 years and have four children and five grand-

children. Now in their late fifties, they have lived around Durban since the mid-1950s. Both of them originated in rural areas which they left in search of urban-based job opportunities. By and large, except for a cold and flu, they have not had any serious illnesses in the family. That was until Mrs. Bisho fell seriously ill early in 1996.

At the beginning, she complained about a stomachache that kept her awake at night and did not seem to respond to pain killers. A neighbor suggested that she be taken to a hospital for examinations. She refused to see a medical doctor. She feared that the doctors would say that she had either ulcers or, worse, cancer and would then operate on her (the Zulu word for an operation is ukuhlinza, a word which is also used to refer to the act of killing and cutting open a cow, goat, or sheep). Mr. Bisho also considered an operation as a dicey undertaking. They both agreed, instead, to seek an African traditional healer (inyanga).

They went to see a supposed *inyanga* who operated out of Tongaat. The *inyanga* diagnosed the illness as stomach-based sores; a result of witchcraft from a jealous neighbor. He said that Mrs. Bisho had stepped on umuti (a cursed object) inside her own yard. To help her, he gave her two sets of medicines – one set was for Mrs. Bisho to use in order to cure the sores, and the other set was both to "cure" Mrs. Bisho's house and yard as well as to prevent further witchcraft. After paying a sum of R80.00, Mr. and Mrs. Bisho left for home.

After a week of using the alleged inyanga's medicines, Mrs. Bisho was not improving. Her legs were swollen, and she was losing strength. Mr. Bisho heard about a "white" doctor who could cure Mrs. Bisho without operating on her. The doctor's "surgery" was in Dalbridge – about 22km south of Kwamashu.

The last time I saw her alive was the day before her second radiation for cervical cancer. I received a message at work the following day, informing me that she had passed away.

5. Reasons why traditional healers are preferred over modern doctors

Mr. and Mrs. Bisho, in the case above, preferred to consult an *inyanga* about Mrs. Bisho's illness because they did not want her to be operated on since, to them, surgery involved too much risk. In many instances, such views combine with similar ideas about modern medicine and its procedures resulting in large numbers of Africans opting to visit traditional healers rather than modern doctors and hospitals, often with tragic consequences.

Among the reasons for not visiting modern doctors and hospitals are issues of language and communication, cultural codes, privacy, poor facilities, the desire for immediate relief, and belief in African explanations of illnesses. They are discussed below.

6. Language and culture

The best medicine for any ailment is for the ailing person to know exactly what is wrong with them, how the illness was contracted, and how it could be cured. This is an area in which modern medicine still has a long way to go, especially when it deals with African people in South Africa. Since the doctors and nurses learn in English, they normally are unable to describe and discuss the ailment with someone who does not understand English. Quite often, Africans who visit doctors are examined and then given either injections or medications and then asked to return some time later – without being told what is wrong with them and what medication they were given, and how it was supposed to help them (Devisch, 1993).

In some of the cases where an explanation was attempted, usually a short-hand of an explanation, if any at all, was substituted for informative discussion with patients. A good example of this was that innocuous procedures such as operations on a hand or foot were translated in Zulu as ukuhlinzwa, a word which conjures up the slaughter of an animal, the removal of its skin, and the dissection of its body and its parts. This understanding of an operation produces fear and trepidation.

This is not to say that African traditional healers are better at explaining such ailments. But the cultural context is such that they are able to discuss ailments in terms and beliefs that people understand, e.g. witchcraft is the cause of disease (Comaroff, 1993).

Privacy

Closely related to the language issue is concern about privacy, especially when the afflicted do not want others to know of their affliction. Regarding private afflictions, the hospitals that township residents can afford to attend are normally public hospitals. As such, attendance at such places puts one at the risk of being seen by other people and, especially, by people one knows. Instead of going to public hospitals, people affected by diseases choose to go to distant African doctors, who do not keep documents, where they are less likely to be turned into public spectacles (Sindiga, 1995).

Poor facilities

One of the major reasons Africans turn away from modern medicine is the poor facilities in hospitals. In many of the public hospitals they visit, Africans are made to wait inordinate amounts of time – waiting in waiting rooms for doctors who may never come.

Due to the poor funding for public hospitals reserved for Africans, the staff of such hospitals work with outdated facilities, are normally overloaded with work, and are frequently required to do more than their share of work. Sometimes the racist attitudes of hospital officials and doctors contribute to African reluctance to approach modern hospitals (Green, 1994).

The quest for a magic pill

In some cases where there is a belief in modern medicine, a crisis is sometimes reached when a person is taken to a hospital but does not get well. Pressure is exerted on relatives to take such a person to traditional healers. There is ample evidence in the townships of people who got well after they had been taken from hospitals – some after hospitals had given up on them – to African doctors. However, it is also true that some people are taken from traditional healers to hospitals where they eventually get well.

The quest for a magic pill that produces immediate relief has produced an alarming increase in the manufacture of medicines which are supposed to cure illnesses which are not indigenous to South Africa, such as high blood pressure and even cancer and AIDS! If the person dies, then it means that the pills don't work. In many instances, such medicines are priced significantly lower than those charged by modern pharmacists (Pool, 1994).

There are some who claim to be able to cure even such currently "incurable" ailments such as cancer and AIDS. Such claims are used by the believers as evidence of the potency of all African medicines over all modern medicines. The question of whether and how cancer and AIDS actually get cured by these medicines becomes inconsequential. The issue of the effectiveness of African medicines brings up another important issue, i.e., the qualification of traditional healers to practice their work.

Traditional healing as a calling

In the past, traditional medical practice was a *calling* and not a vocation. Traditional healers were chosen by ancestors who demanded that they forsake all their other aspirations. After being chosen, they spent months and sometimes years under the tutelage of a senior traditional healer. Often, they were trained to cure certain but not all illnesses. When they "graduated," they could only try to assist people who suffered from illnesses for which the traditional healer was qualified (Sindiga, 1995).

Traditional healing as a business

The modern environment is very different. Quite often, it is not clear whether and how many practitioners really become traditional healers. This uncertainty creates an environment within which quacks and multifarious characters of doubtful equanimity – who claim to be traditional healers – proliferate. Characterizing what "traditional healers" do as "business" is not to degrade it, but it is to highlight the increasing pecuniary nature of the practice. Even the practitioners regard it as a career (Sindiga, 1995).

It would be one thing if charlatans only relieved sick people of their hard-earned money, but the fact that they dissuade (and sometimes forbid) them from consulting other doctors, especially modern doctors, puts their operations in a serious light. Like Mrs. Bisho, many Africans do not consult doctors and hospitals because, among other things, charlatans tell them that if they are

operated on they would die. Many people have refused to take modern medicines which are proven either to cure or control certain illnesses (such as hypertension and diabetes) because they believe that certain illnesses are only cured by traditional medicine and using modern medicine may have tragic consequences (Janzen, 1992).

7. Institutional change supporting successful health technology transfer

Although there are formidable structural and cultural obstacles to wider participation of the African population in the modern health care system, the South African Department of Health is undertaking fundamental institutional change with the participation of traditional healers which facilitates health technology transfers to the under-served (DOH, 1997). The cervical cancer screening program, which has been successfully initiated in rural and urban township clinics of the Province of the Eastern Cape, is an example of a health technology (i.e., preventive medicine practice) transfer that has been supported by the new institutional environment that actively seeks the involvement of practitioners of traditional African medicine (DOHW, 1998). The introduction of routine cervical cancer screening exams into these clinics would not have been possible without a new integrated primary health care project (the EQUITY project) that provided new practice guidelines, additional staff and equipment, and better referral linkages to health centers and hospitals. Furthermore, community health educators, an innovation brought from the neighboring country of Botswana, were employed to inform local women and their families about the cervical cancer screening and reproductive health program and to obtain the support of traditional healers. The health educators, who are paid community representatives, actively seek out practitioners of African medicine, discuss the importance of the new reproductive health program with them, and request that they refer their female patients to the clinic for exams. Traditional healers who refer women to the clinics for the new reproductive health program are recognized with certificates in village or township ceremonies. Recently reported province-wide data suggest that the rural and urban clinics are providing cervical cancer screens and reproductive health exams to thousands of under-served women (DOHW, 1998).

8. Conclusions and implications for technology transfer

The intersection of rural poverty, urban socioeconomic conditions, and the inability of formal education to disseminate basic scientific reasoning creates a fatalism and powerlessness which renders many people of African descent in both rural and urban areas partial to traditional healers and susceptible to charlatans who perform magic tricks to "solve" their social, political, economic, legal, psychological, and medical problems. Despite the barriers of poverty, culture, and lingering racism which limit the access of many Black South Africans, and other people of color, to new health technology, market forces will continue to transfer the latest health innovations to this recently reopened market. Wider participation in the benefits of modern medicines, medical technology, and health care organization will depend upon improved economic standards, universal educational programs supporting a scientific perspective on health and illness, and the development of an integrated health care system which addresses the inequities of the apartheid era and provides a significant role to legitimate traditional African medicine (such as the Equity Project now ongoing in the province of the Eastern Cape).

An analysis of the successful transfer and adoption of cervical cancer exams now occurring within clinics participating in this project shows us the importance of key institutional mechanisms which could be applied to additional health technology transfers that target the under-served population in South Africa. First, successful health technology transfer to the historically disadvantaged population should happen in an *integrated* (as opposed to a fragmented) healthcare system which provides such resources as new practice guidelines, additional staff and equipment, and good referral linkages to higher level care (e.g. health centers and hospitals). Second, *community health educators*, who are respected members of their communities must work effectively with lo-

cal traditional healers and try to win their support, or at least neutralize their opposition to the new health technology. It is especially significant that the community health educator role is modeled after a similar position in a neighboring *African* country, Botswana. Perhaps many of the institutional mechanisms that need to be put into place to bring new health technology to underserved South Africans are to be found in other African countries rather than North America and Europe.

Ultimately, bringing elements of traditional African medicine and modern South African health care together in an integrated system is a challenge which will require cultural accommodation from both health care professionals and traditional healers. This crucial relationship will require culturally sensitive negotiation and compromise.

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