

Use of traditional medicine versus use of the community-based primary health care clinic by the San community at Platfontein

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Abstract

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Introduction: Working amongst a San community led to the observation that, despite the availability of modern healthcare, high mortality and morbidity associated with disease, such as dehydration, malnutrition and tuberculosis, still prevailed. This study aimed to determine how traditional beliefs and customs influenced the utilisation of Western medicine.

Methods: An observational-descriptive study was conducted. Consenting patients, facilitated by interpreters, completed questionnaires during consultations conducted by nurses and the principal investigator at the Platfontein primary health care (PHC) clinic.

Results: Of the 113 participants, two-thirds were female. The median age was 40 years; 56.7% lacked formal education; 42.5% conversed only in their native tongue. The initial use of the PHC facility was high (71.4%), even though 37% of the participants visited a traditional healer in the preceding year. Circumcision was the condition for which traditional healers were consulted most commonly (28.8%). Conditions preferably requiring clinic visitation were coughing (51.4%), pain (35.1%) and diarrhoea (34.2%). Of the participants leading mostly a traditional lifestyle (n = 48), 30.6 % indicated that they did not use traditional medicine or healers; 72.9% indicated that illness could be caused by a spell. Of the participants not leading a traditional lifestyle (n = 41), 85.4% indicated that they did not use traditional medicine; 41.4% indicated that illness could be caused by a spell.

Conclusion: The assumption that the mortality and morbidity observed for certain conditions were due to the preference for traditional medicine in this community could not be confirmed. Doctors working amongst isolated communities or in multicultural environments, however, should recognise that traditional medicine still plays a role in the health care of their patients.

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Introduction

In the first Traditional Medicine Strategy proposed by the World Health Organization (WHO), it was noted that many countries worldwide have two healthcare systems, one practising traditional and the other Western (in other words, modern) medicine. It was recommended that the integration of and cooperation between these two approaches to healthcare should be encouraged.¹

Traditional medicine and healers are difficult concepts to describe and define in all-inclusive terminology due to their extreme complexity and the wide variation amongst the different traditional healthcare systems practised globally. The WHO, however, has defined a traditional healer as a person who is regarded by the community in which she or he lives as capable of providing health care by using plant or

vegetable, animal or mineral substances as well as certain practices based on social, cultural or religious traditions. These abilities also encompass the suitable application of the knowledge, attitudes and beliefs prevalent in the specific community regarding physical, spiritual and social well-being, including the causes of disease and disability.¹

In his book *The Nahro Bushmen of Botswana: Tradition and change*, Mathias Guenther² explained the reluctance of a sick Bushman (San) at Ghanzi in Botswana to go to a local hospital. According to the patient, the hospital's medicine, in other words Western medicine, would not be able to cure him, as he was convinced that his illness was due to a spell that had been cast on him. Only very sick people in this community could be persuaded to be admitted to hospital, where many of them died due to the severity and advanced stage of their conditions. Since tuberculosis (TB) was a

major problem in these communities, patients often had to be forced by health authorities to be admitted to hospital. Guenther argued that, from the sick Bushman's frame of reference, his fears were not unfounded.²

In San social structures, specific people are recognised to have certain abilities or powers; such people include traditional healers. It is believed that they have the power to heal or even cause disease over a distance by means of magic or the casting of spells.^{3,4} According to Guenther,² one of the types of disease perceived by the San is the so-called European diseases, their treatment being perceived to be in the hands of Western health care workers and medicine; injuries are also referred to Western doctors.²

Following the independence of Namibia in 1990 and the subsequent withdrawal of the South African Defence Force (SADF) from Namibia and Angola, approximately 5 000 San were settled at Schmidtsdrift in the Northern Cape Province after they had been moved by the South African government from these countries. Most of the men in this group had been employed by the SADF as trackers during the so-called bush war lasting more than 20 years. After a land dispute, the farm Platfontein of 12 500 ha just outside Kimberley was bought by the Department of Land Affairs and handed to the Communal Property Association representing two tribes, the !Xun and !Khwe, consisting of 3 500 to 3 700 and 1 100 to 1 300 individuals, respectively.^{5,6}

The first author worked for more than three years in the Kimberley Hospital Complex, which included rotation to the Platfontein Primary Health Care (PHC) clinic. The observation that prompted the research presented here was that people from the Platfontein community frequently acquired medical attention only at a very late stage of disease. Quite often, these conditions (which included TB, cervical cancer and gastroenteritis with dehydration, especially in children) could have been treated successfully if help had been obtained in time.

Based on personal observation, the morbidity and mortality associated with dehydration, malnutrition and TB seen in this community were very high, despite the availability of modern medicine. The reasons for patients not making use of the health care facilities at their disposal were consequently questioned. The aim of this study was to determine whether the influence of traditional beliefs and customs regarding medicine and doctors (or healers) played a notable role in the utilisation of Western medicine.

Methods

An observational-descriptive study design was used to conduct the investigation. Information was obtained through the voluntary completion of questionnaires by visitors to the Platfontein clinic.

The Platfontein clinic is open every working day of the week and approximately 40 adults are seen per day. People who visited the clinic between 29 October and 13 November 2007, either as patients or as companions of patients, were requested to complete a questionnaire with the assistance of an interpreter. Participants had to be 18 years of age and older.

Questionnaires were completed during personal interviews by either the first author or nurses working at the clinic. The six interpreters who assisted with the acquisition of information were employed by the clinic to facilitate communication between the patients and the clinic staff. The researcher was experienced in working with the interpreters, as he had previously been employed as a general practitioner at the clinic. The interpreters were familiar with the clinic's working circumstances and conditions, as well as with the translation of health-related questions. They were also members of the community, which contributed to improving interaction with the patients and the interpretation of their responses.

The questionnaires consisted of 23 questions dealing with the demographic details, practices and opinions of traditional medicine and of the clinic and hospital. The demographic questions were closed questions, as were the questions regarding practices, with options such as 'always', 'sometimes' and 'never'. The number of times that a respondent had visited a traditional healer in the preceding year was elicited, as was how long ago the last visit to the traditional healer had occurred. Open questions were asked to determine the conditions for which the respondents thought traditional medicine worked better than the clinic's medicine, and vice versa, and to determine the respondents' opinions regarding what makes a person sick.

The questionnaires were discussed with the nurses and the interpreters beforehand. They were also properly informed regarding the purpose of this study and the meanings of the questions. A pilot study was conducted at the Platfontein clinic through the completion of five questionnaires with the assistance of the interpreters. The results obtained from the pilot study were not included in the main study.

The participants gave written, informed consent to be included in this study. Participation was voluntary, anonymous and confidential and had no influence on the patients' treatment at the clinic. Approval to conduct the research was obtained from the Ethics Committee of the Faculty of Health Sciences, University of the Free State (UFS) and from the Northern Cape Province Department of Health.

The analysis of the results was performed by the Department of Biostatistics, Faculty of Health Sciences, UFS. The results were summarised by frequencies and percentages.

Results

One-hundred and thirteen (113) questionnaires were completed from 29 October to 13 November 2007. Approximately two-thirds (65.1%) of the participants were female. The age of the participants ranged from 18 to 94 years. The median age of the group was 40 years, with a median of 46 years for the male and 34.5 years for the female participants. The majority (70.6%) of the participants were 50 years of age and younger.

Sixty-four (56.7%) of the participants had not received any formal education, while 21.6% of the participants had continued with schooling after Grade 7 (in other words received secondary education). Six (5.4%) of the participants had completed Grade 12. No information was obtained with regard to further (in other words post-secondary) education.

Only one participant's mother tongue was Afrikaans, while 46.8% of the participants' mother tongue was !Xun and 52.3% of the participants' mother tongue was !Khwe. With regard to the ability to speak languages other than their mother tongue, 42.9% of the participants (information was lacking for one participant) indicated that they were not skilled in any other language. The languages spoken by the remaining participants are shown in Table I. Some of the participants were skilled in more than one other language in addition to their mother tongue.

Table I: Languages spoken by the participants in addition to their mother tongue

| Language | Number of participants (n = 112) | Percentage |
|------------------------|----------------------------------|------------|
| No additional language | 48 | 42.9 |
| Afrikaans | 54 | 48.2 |
| English | 23 | 20.5 |
| Setswana | 2 | 1.8 |
| !Xun | 16 | 14.3 |
| !Khwe | 10 | 8.9 |
| Kavango | 1 | 0.9 |

The participants were asked whether they used traditional medicine and visited traditional healers. Their responses are summarised in Table II.

Table II: Participants' use of traditional medicine and healers

| | Number of participants (n = 112) | Percentage |
|-------------------------------------|----------------------------------|------------|
| Traditional medicine | | |
| Do not use it | 63 | 56.3 |
| Obtain it from a traditional healer | 35 | 31.3 |
| Prepare their own | 14 | 12.5 |
| Traditional healers | | |
| Frequency of visit | | |
| Always | 29 | 25.9 |
| Sometimes | 32 | 28.6 |
| Never | 51 | 45.5 |

More than 70% of the participants stated that they would initially visit the clinic in the event of illness, rather than a traditional healer. Approximately 37% of the participants indicated that they had visited a traditional healer in the year preceding this study. Only 4.8% of the participants had done so only once, while 88.6% of the participants who had visited a traditional healer indicated more than one visit in the preceding year. The number of visits to a traditional healer in the year preceding this study is summarised in Table III.

Table III: Participants' number of visits to a traditional healer in the year preceding the investigation

| Number of visits | Number of participants (n = 104) | Percentage |
|------------------|----------------------------------|------------|
| No visit | 60 | 57.7 |
| 1-5 times | 27 | 26.0 |
| 6-10 times | 13 | 12.5 |
| 11-15 times | 1 | 1.0 |
| 16-20 times | 3 | 2.9 |

Approximately 30% of the participants indicated that traditional medicine was always effective, as opposed to 59.5% who believed that the medicine provided by the clinic was always effective. The participants' opinion on the efficacy of traditional medicine as opposed to the clinic's medicine is shown in Table IV.

Table IV: Participants' beliefs regarding the efficacy of traditional medicine and medicine provided by the clinic

| | Number of participants (n = 111) | Percentage |
|------------------------------------|----------------------------------|------------|
| Traditional medicine | | |
| Always effective | 33 | 29.7 |
| Sometimes effective | 37 | 33.3 |
| Never effective | 41 | 36.9 |
| Medicine provided by clinic | | |
| Always effective | 66 | 59.5 |
| Sometimes effective | 29 | 26.1 |
| Never effective | 16 | 14.4 |

The participants were asked to name any conditions for which they believed traditional medicine and medicine provided by the clinic were more effective. With regard to traditional medicine, 28.8% of the participants were of the conviction that traditional medicine was not more effective for any condition. Medicine provided by the clinic was indicated as more effective for 35 different conditions and traditional medicine for 37 conditions. Less than 5% (4.5%) of the participants were of the opinion that traditional medicine was more effective in the treatment of HIV infection than the other, while the same percentage of participants was convinced of the opposite (in other words medicine provided by the clinic was more effective against HIV infection than traditional medicine). The conditions and/or diseases indicated by more than 10% of the participants

with regard to the effectiveness of both types of medicine are listed in Table V.

Table V: Conditions and/or diseases listed by more than 10% of the participants for which they believed traditional medicine or medicine provided by the clinic was more effective

| | Number of participants (n = 111) | Percentage |
|------------------------------------|-------------------------------------|------------|
| Traditional medicine | | |
| Circumcision | 32 | 28.8 |
| Happiness and money | 19 | 17.1 |
| Influenza | 17 | 15.3 |
| Hurting or killing people | 14 | 12.6 |
| Coughing | 13 | 11.7 |
| Diarrhoea | 12 | 10.8 |
| Medicine provided by clinic | | |
| Coughing | 57 | 51.4 |
| Pain | 39 | 35.1 |
| Diarrhoea | 38 | 34.2 |
| Headache | 34 | 30.6 |
| TB | 29 | 26.1 |
| Fever | 28 | 25.2 |
| Blood pressure | 27 | 24.3 |
| Nausea and vomiting | 21 | 18.9 |
| Influenza | 13 | 11.7 |

The participants were requested to list what they believed were the causes of disease. Twenty-seven (27) different causes or reasons were given. The causes of disease noted by more than 10% of the participants are shown in Table VI. Sixty-two per cent (62%) of the participants were convinced that it was possible to become ill as a result of someone else putting a spell on them.

Table VI: Causes of disease as perceived by the participants

| Cause of disease | Number of participants (n = 109) | Percentage |
|-------------------------------------------|-------------------------------------|------------|
| Poor sanitation and problems with toilets | 73 | 67.0 |
| Too little food and money | 42 | 38.5 |
| Too little or dirty water | 38 | 34.9 |
| Domestic problems | 32 | 29.4 |
| Contact with TB cases | 29 | 26.6 |
| 'Germs' | 25 | 22.9 |
| HIV | 15 | 13.8 |

Table VII: Association between leading a traditional lifestyle and belief with regard to being put under a spell as a cause of illness and the use of traditional medicine

| | Can a person be made ill by being put under a spell? | | | | Do you make use of traditional medicine? | | | | | |
|------------------------------------------------------------------------------|------------------------------------------------------|------|----|------|------------------------------------------|------|-----------------|------|----|------|
| | Yes | | No | | Prepare own | | Obtain from TH* | | No | |
| | n | % | n | % | n | % | n | % | n | % |
| Do not lead a traditional lifestyle at all (n = 41) | 17 | 41.4 | 24 | 58.5 | 1 | 2.4 | 5 | 12.2 | 35 | 85.4 |
| Lead a traditional lifestyle to a limited extent (n = 15) | 11 | 73.3 | 4 | 26.7 | 0 | 0 | 4 | 26.7 | 11 | 73.3 |
| Lead a traditional lifestyle to a great extent (n = 48; n = 49) [#] | 35 | 72.9 | 13 | 27.1 | 12 | 24.5 | 22 | 44.9 | 15 | 30.6 |

*TH = traditional healer; [#]48 participants answered the question "Can a person be made ill by being put under a spell?"; 49 participants answered the question "Do you use traditional medicine?"

In response to the question "What should be given to a child with diarrhoea?", 60.6% of the participants indicated that the rehydration compound provided by the clinic should be used. Another 5.5% of the participants indicated that water should be used, while 33.0% recommended a herbal mixture and 0.9% said that a soft drink should be given to a sick child.

Although 39.3% of the participants had never been to Kimberley Hospital, 63.3% of them felt that people going to the hospital were always cured. Thirteen per cent (13%) of the participants were of the opinion that hospitalisation never resulted in a patient being cured.

More than half (51.4%) of the participants indicated that they visited the clinic at Platfontein when they were sick and required treatment, while 26.2% went to the clinic for TB follow-up. The nutritional supplementation programme was indicated by 8.4% of the participants as their reason for visiting the clinic, while 7.5% visited the clinic with blood pressure problems and/or other chronic diseases, and 3.7% to obtain information or support from the Love Life HIV programme.

Although 40.2% of the participants pointed out that they were involved in traditional dances (the so-called trance dance), less than 25% (23.9%) were of the opinion that these dances cured people from illness.

The participants who reported that they did not at all lead a traditional way of life represented 38.7% of the sample, while 47.2% indicated that they followed a traditional lifestyle to a great extent. Sixty-three per cent (63%) of the total group were of the conviction that a spell could be cast over a person. The association between leading a traditional lifestyle and belief with regard to becoming ill due to being put under a spell (not answered by nine of the participants) as well as the use of traditional medicine (not answered by eight of the participants) is shown in Table VII.

Discussion

Recent interest in the use of traditional medicine by patients affected and afflicted by AIDS has resulted in many publications addressing the use of traditional healers in this pandemic. We found no published study referring to

the utilisation or to perceptions regarding the utilisation of traditional medicine versus Western medicine related to beliefs and lifestyle in a South African context.

A major limitation of this study is that, for logistical reasons, it had to be based at the Platfontein clinic. The results reported here consequently reflect only that part of the community that does make use of this facility. It is unknown what percentage of the Platfontein community does not make use of the clinic.

The relatively low level of scholastic training, with 78.3% of the participants having either no education or having completed only primary education, could be regarded as a major contributing factor to the poor socioeconomic circumstances of the Platfontein community. Stekelenburg et al⁷ reported that the incidence of visits to traditional healers decreased with more advanced levels of scholastic training.

In a literature review, Schouten and Meeuwesen⁸ reported that, due to the wide variety of study designs and research questions, no definite conclusion regarding the cultural variability of doctor-patient communication could be reached. Some articles included in the review, however, reported considerable problems in patient-doctor communication when the two parties came from different cultural and ethnic backgrounds. In such cases, both patients and doctors are prone to showing less positive affect towards each other. Patients, furthermore, tend to be less communicative during consultations with a culturally or ethnically different doctor. This lack of comfortable communication due to cultural and language divergence could explain the unwillingness of minority groups to attend culturally foreign health care facilities, such as hospitals and clinics.⁹ The reviewers proposed a model for future research in this field. Our finding that 42.9% of the participants (see Table I) could speak and understand only their mother tongue could be considered an additional contributing factor to the poor socioeconomic conditions of the Platfontein San community. Their linguistic differences and, consequently, their inability or limited ability to communicate with other cultural groups and potential employers render Platfontein a social island. These language-related difficulties could also be expected to have an impact on the community's utilisation of health care facilities and emphasise the importance of the use of interpreters at the Platfontein clinic. It should be noted, however, that the interpreters used at the clinic in this study could have caused bias, as they themselves could have been prejudiced towards Western medicine. Although skilled interpreters are hard to find, it is recommended that independent interpreters from the broad community should rather be used in the event of any follow-up studies.

In this study, 45.5% of the participants (see Table II) indicated that they never visited a traditional healer, which is notably lower than observations reported by Campbell.⁴ This finding confirmed the researcher's supposition that traditional healers were still actively practising in the Platfontein community, although the frequency of visits to these healers was lower than expected. More than one-third of the participants visited traditional healers as well as the clinic, and 71.4% preferred to visit the clinic first when seeking help for an illness, showing that the Platfontein community, despite its cultural point of reference, possibly regarded the clinic as a reliable source of PHC. This conclusion could be speculative, however, due to the changing disease profile, including TB and AIDS, possibly compelling the community to make use of Western facilities.

According to the results shown in Table V, 51.4% of the participants indicated that the medicine provided by the clinic was more effective than traditional medicine for the treatment of coughing, as opposed to only 11.5% who felt that traditional medicine was more effective. An increasing incidence of TB has been reported in the Platfontein community⁶ and it could therefore be argued that, in the event of coughing related to TB, antimycobacterial agents provided by the clinic would have a more effective outcome than traditional medicine, as reflected by the participants' opinion.

It was noteworthy that three of the possible causes of disease named by more than 30% of the participants (see Table VI) were related to poor socioeconomic circumstances and poverty. Poor sanitation and problems with toilets, as well as the shortage and poor quality of water, should, therefore, be addressed by the authorities responsible for social development and basic service delivery, in other words the Sol Plaatje Municipality in Kimberley and the Northern Cape Provincial Government. Poverty and domestic problems should be addressed by means of job creation to alleviate unemployment and support from social welfare professionals.

Although 56.3% and 45.5%, respectively, of the participants indicated that they did not use traditional medicine and never visited traditional healers, 63% were of the conviction that a person could become ill as a result of being put under a spell. More than 40% of the participants who did not lead a traditional lifestyle were, furthermore, of the opinion that disease could be caused by casting a spell over someone. These observations suggested a strong influence of perceptions, religion and cultural background on the participants' knowledge regarding the causes of disease.

With regard to the treatment of diarrhoea in children, 60.6% of the participants indicated that children should be given the rehydration solution provided by the clinic. This could be attributed to a marked improvement observed in patients

using the clinic's rehydration therapy as opposed to a herbal mixture, which was indicated by one-third of the participants as the treatment of choice for children with diarrhoea. The use of herbal mixtures and pure water (as indicated by 5.5% of the participants) in an attempt to rehydrate one in three children with diarrhoea is nevertheless disturbing, as inadequately managed dehydration in small children could have a rapid fatal outcome.^{9,10}

In contrast to Stekelenburg et al,⁷ who reported that only 4% of the population in their study had never visited a hospital before, 39.3% of the participants included in this study indicated that they had never been to Kimberley Hospital, which is approximately 15 km away from Platfontein. This observation could be a reflection of the degree of isolation experienced by the Platfontein community. It was encouraging that 87.2% of the participants were positively inclined with regard to the hospital 'always' (63.3%) or 'sometimes' (23.9%) providing a cure for disease, as opposed to 12.8% who felt that being admitted to the hospital never resulted in being cured. The possibility of bias cannot be ruled out, however, as this study included members of the community who had been exposed to Western medicine by visiting the clinic. Follow-up studies should include the broad community and not only patients who use the clinic for health-related problems.

Southern Africa has approximately 69 000 traditional healers, 25 000 of whom practise in South Africa.¹¹ The integration of traditional medicine into the public health system has already reached an advanced stage, with its recognition, development and protection supported and promoted by National Government and the Department of Health.¹² Although modern medicine may be regarded by many doctors and health care providers as 'superior' to traditional medicine, it should be kept in mind that traditional healers provide for the health care needs of more than 80% of the sub-Saharan population. They are, furthermore, regarded by the communities that they serve as highly knowledgeable about health-related cultural beliefs, principles and practices and are highly respected members of their communities.¹²

Doctors working in PHC facilities in remote areas of the country or amongst isolated communities, such as the San people at Platfontein, should continuously remain aware that, although their patients are modernised to various degrees, traditional medicine still plays a role in the daily health care needs of many of the patients who visit their clinics.

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