AFRICAN TRADITIONAL HEALERS: THE FUTURE?

In the *South African Health Review* 1999, a very important section concerns traditional healers, for the government has committed itself to their involvement in official health care services, i.e. healers must be brought into the health resources pool.

In South Africa, there are about 200 000 healers, with a healer to population ratio of about 1 in 200. There are about 25 000 doctors of modern medicine. It has been estimated that about 80% of African patients consult a traditional healer before going to a professional nurse or medical doctor, and some 60% of all babies are delivered by traditional birth attendants.1,2

An excellent review on traditional healers in South Africa was compiled by Rajendra Kale.3 In the categories of healers, first, there are the *inyanga*, who are herbalists and possess extensive knowledge about curative herbs and medicines of animal origin. Most *inyangas* are men. Then there are *isangomas* who are diviners, almost all of whom are women. They determine the cause of illness using ancestral spirits. A person cannot choose to become a diviner. Only a person ‘called’ by the ancestors can become one. Training for a traditional healer varies from a few weeks to up to 10 years and depends on the ability of the apprentice. *Umthandazi* are faith healers who are professors Christians. They belong to one of the independent African churches, and they heal by prayer, by using holy water or ash, or by touching a patient. Traditional birth attendants are usually elderly women, respected in society for their skills. Their apprenticeship lasts up to 15–20 years. Birth attendants do not charge for their services, but they may accept gifts. More detailed information on the subject is given in a booklet entitled *Bridging the Gap.*3 An important aspect, published in a review by an African traditional healer4 in *The Lancet* millennium issue, is that ‘in the African context, illness always has a reason. The reason is the most important aspect of the disease—more important than an exposition of the illness itself.’ In the African traditional setting, the question: ‘Why am I ill?’ is more important than ‘What is the nature of my illness?’ It follows, therefore, that a detailed biomedical explanation based on the germ theory is foreign and irrelevant to African concepts of illness. This aspect of understanding was also noted by Marianna Hewson, following her interviews with six traditional birth attendants.5

In principle, the World Health Organization (WHO) strongly supports the further promotion, development and rational use of traditional medicine throughout the world, and considers that this branch of medicine makes a very significant contribution to the various efforts being made to achieve health for all.6 Hewson, from her interviews, concluded that ‘the style of healing they practice has value in today’s medicine’.5

However, there are numerous problems. As pointed out in the *South African Health Review,* traditional healers have as yet no statutory position; the government does not financially support their services. It was emphasized that there must be more standardized training of traditional healers, and that there must be an authority and mechanisms to get rid of quacks and charlatans who tarnish the image of this kind of health care. Only then could they contribute to a multi-faceted model of health care in line with the varied needs of the diverse populations in South Africa. It was stated that, in the present economic climate and widespread unemployment, there has been a marked increase in the ranks of traditional healers, among whom there are, unfortunately, many charlatans. It was considered that of the 80 000 persons practising traditional healing in the province of Gauteng (18% of the total population), only about 10% are bona fide healers, i.e. healers who abide by the strict code of their vocation. In passing, over half a century ago, the high proportion of charlatans among healers was emphasized by Michael Gelfand in his pioneering book *The Sick African.* An example of the effect these charlatans could have is illustrated by the finding that of the patients with poisonous intoxication admitted to a hospital near Pretoria, 15% were ascribed to traditional ‘medicines’.1

An indication of the extent of the lack of training which prevails in another African country was given in a recent enquiry into the ‘Characteristics of traditional birth attendants and their beliefs and practices in the Offot Clan, Nigeria’.7 It transpired that the majority of the attendants were illiterate and had no previous experience nor training, even informal, when they took on the traditional birth attendant’s role. Ignorance about maternal complications during childbirth and the appropriate treatment was evident for most of the group. The survey clearly showed that educational programmes for attendants and better integration into the country’s health care system are essential for lowering maternal mortality and morbidity rates in areas where most mothers are neither open to, nor have access to, professional care in childbirth.

In the conclusion of his review, Kale4 considered that the establishment of a comprehensive pharmacopoeia of traditional medicines is perhaps a distant dream. Weeding out the charlatans from the trained healers is the logical first step in sorting out the dilemmas surrounding traditional healers. It was considered that this task is best done by the healers themselves. As Daniel Ncayiyana, editor of the *South African Medical Journal,* summarizes, ‘We have to recognize the traditional healers. Let them regulate themselves; let them create a system of registration. There are many charlatans among them. We need to know what training is required, how they actually certify themselves; then we just have to recognize them because they are indeed part of the health care delivery system.’

As to the efficacy of traditional remedies, unfortunately, there have been no studies.3 They are believed to be effective in diarrhoea, headaches and other pains, and in sedating patients. Success in treating psychological problems is well known and often recognized.2 Lack of knowledge was also stressed in comments made on the results of a community survey of traditional medical practitioners, half of whom were qualified, in the high-density suburbs of Harare, Zimbabwe.9 It was urged that the treatments used by healers for the various disorders, and, equally important, the outcomes, should be carefully monitored and subsequently studied.

Briefly then, in terms of evidence-based information, knowledge of the effectiveness and benefits of various traditional healing practices is very limited.

A point of great interest is that while there is an enormous need for more information on the subject in the African setting, there are also continuing urges for more information in western coun-
tries regarding the benefits resulting from complementary health practices and alternative medicine.

In 1998, in the prestigious New England Journal of Medicine, there was a very outspoken editorial: 'Alternative medicine—the risks of untested and unregulated remedies'. It stated that 'such constitute a huge and rapidly growing industry, in which major pharmaceutical companies are now participating'. 'Alternative medicine... often disparages modern science, and relies on what are purported to be ancient practices and natural remedies... healing methods such as homeopathy and therapeutic touch are fervently promoted despite the lack of good clinical evidence of effectiveness... It is time for the scientific community to stop giving alternative medicine a free ride... Alternative treatments should be subjected to scientific testing no less rigorous than that required for conventional treatments.'

In the USA, even a decade ago, one in three adults was using unconventional therapy. In Australia, a recent enquiry concluded that 'there is evidence... of widespread acceptance of acupuncture, meditations, hypnosis and chiropractice, by general practitioners... These findings generate an urgent need for evidence of these therapies' effectiveness.'

To come back to traditional healers, and to reiterate, clearly they must have more effective training, and more must be known of the benefits resulting from treatments. This need is widespread, bearing in mind, as recently stressed, that 'about 80% of the world's population does not have access to western medicine and therefore depends on traditional medical practices'.

While there is some despondency over the situations described, it must be kept in mind, first, that in many western populations, current survival times are the longest ever, 75–80 years; and, second, that in Africans in South Africa, despite adverse circumstances, the mean survival time of 61 years is commendable, although unfortunately, it is falling due to the HIV/AIDS epidemic.

REFERENCES


A. R. P. WALKER

Letter from Mumbai

RESEARCH, INDIAN STYLE

Experiences as a very modest research worker, referee for research projects and member of some scientific and ethics committees have provided me with insights that I would like to share with readers of this Journal. I believe that our research leaves much to be desired. Corrective measures need not necessarily require infusion of more funds. Simple methods, sincerely applied, might work.

In most cases, the problem starts with the real reason for doing research. It is not a compelling need to satisfy scientific curiosity or to further the bounds of existing knowledge. Nor is it a need to address relevant local problems that will not be attended to in the better-developed scientific communities of the West. Almost always, research projects are put up for personal advancement, padding the 'curriculum vitae' or one-upmanship. Other reasons are even more puzzling. I have just seen a proposal to set up a polymerase chain reaction assay that was handed in at the hospital administrator's suggestion so that research funds could be used to establish a paying laboratory service!

It is rare to find a novel idea or an attempt at solving a hitherto perplexing locally important scientific conundrum presented to a funding agency. Much of what is sent in fits the definition of 'research', duplicating what has already been learnt. Only a few studies genuinely need repetition purely on the grounds that we are studying an Indian population.

Proposals often list a score or more individuals as researchers. On studying their names it is soon evident that just one or, at the most, two individuals will do the actual work. Why were the other names added? Directors, deans and heads of departments continue to consider it their right to be included as researchers on every project. Worse, I know of directors and heads of departments who summon those under them who have written up proposals and refuse to forward these unless their names are included at the head of the list of researchers. In three projects scrutinized recently, where the work is to be done in the laboratory, I learnt that senior clinicians made it very clear that no patients would be referred for the study unless their names were included.

Often, one sees the same name(s) on a large number of research proposals. These individuals are very busy professionals with