

LEARNING FROM TRADITIONAL HEALERS IN SOUTH AFRICA

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In 1999 the South African Ministry of Health (1999) reported that breast cancer was the leading cancer diagnosis among South African women in 1999. More recently, Mqoqi et al (2004) found one in 12 white women and one in 18 ethnically-diverse women were at risk of being diagnosed with breast cancer in South Africa. The National Health Cancer Registry of South Africa has not released national cancer-related statistics since 1999, making more recent morbidity and mortality rates difficult to calculate. However, the growing number of known breast cancer diagnoses tracked to 1999 suggests breast cancer morbidity is on the rise in South Africa.

If the risk of breast cancer morbidity in South Africa is increasing, the risk for developing sequelae as a result of breast cancer treatment will also increase. Of these sequelae, lymphoedema secondary to breast cancer treatment (BCL) is among the most devastating and has both a physical and psychological impact.

All individuals who undergo breast cancer treatment are at lifetime risk for BCL (American Cancer Society, 2006; Brennan and Weitz, 1992). BCL is the result of dysfunctional lymphatic vasculature, resulting in the movement of protein-rich lymph fluid into the interstitial spaces of surrounding tissue. This causes chronic swelling of

the limb or body part and has been associated with increased functional limitations and reduced quality of life. Management of BCL plays a critical part in preventing exacerbations of the condition and reducing risk of infection (American Cancer Society, 2009). Thus, appropriate screening and self-management recommendations for BCL are needed. In order to ensure acceptability and receptiveness, cultural considerations must be integrated into the development of appropriate screening and management programmes. Synergising traditional and Western medicine will play a significant role in addressing these concerns in cultures that still have a strong tradition of alternative medicine.

According to the South African government (2008), nearly 200,000 traditional healers (THs) practice in South Africa. Traditional medicine is described by the World Health Organization (WHO, 2009) as, '... the sum total of the knowledge, skills and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness'. The South African government (2008) estimates about 80% of patients seek traditional medical services. Research shows there is a need for THs to work with Western medical practitioners (WMPs) in providing healthcare in order to optimise care, improve upon the healthcare system, and increase accessibility (Shai-Mahoko, 1996; Peu et al, 2001; de Andrade and Ross, 2005). Little is known about how South African THs care for BCL. Understanding how THs treat BCL can provide a basis for the development of

collaborative relationships between THs and WMPs in treating this and other cancer-related conditions.

The purpose of this small study was to identify the types of treatment and educational guidance provided by THs for BCL. Since THs play such a large role in the healthcare of South Africans, it is necessary to understand how they manage patients with BCL. This understanding will form the basis of a synergistic model of care between THs and WMPs and will show the collaborative effort needed to provide the best care to patients at risk of or who have been affected by BCL.

The University of Missouri in the USA and the University of the Western Cape in South Africa have been collaborating with the shared goals of: increasing understanding of survivors' and traditional healers' ways of managing lymphoedema; designing lymphoedema intervention(s) that combine best practices in Western and traditional approaches; educating the public and healthcare professionals about lymphoedema; and establishing cancer and lymphoedema registries in South Africa to organise data on incidence and prevalence.

This article will describe a recent research project designed to gain a greater understanding of traditional healers' identification and management of lymphoedema or limb swelling after the patient has been treated for cancer. The research findings will be used to assemble a synergistic combination of Western and traditional medicine best practices for lymphoedema treatment and prevention in South Africa. Working collaboratively with healers, nurses, therapists, students and patients will

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facilitate the development of this intervention and education programme.

Methods

Sample

Purposive sampling was used to recruit three THs practising in South Africa. All participants were adult males who identified themselves as THs and were practising with patients. They all spoke, read, and wrote in English, and were capable of providing informed consent. THs 1 and 2 were interviewed in 2007 and practised at their respective storefronts in urban Cape Town. TH3 was interviewed in 2008 and practised from his home in a rural area outside of Bloemfontein, the capital city of the Free State situated in a mostly rural region in South Africa. For this exploratory study, three English-speaking THs were identified for interviews. An interview was conducted with a female TH, but this was not included in this study due to translation issues.

Several classifications of TH exist in South Africa. These classifications include herbalist, isangoma, traditional birth attendant, traditional surgeon, and prophet/faith healer. TH1 identified himself as a herbalist and TH3 self-identified as an isangoma, who also practised as a herbalist, traditional birth attendant, traditional surgeon, and prophet/faith healer. THs 1 and 3 trained in Swaziland and came from lines of several generations of THs. TH1 practised in Kenya before practising in South Africa and was preceded by four generations of THs. TH3 began a five-year training experience at the age of eight, held multiple academic diplomas, and had multiple grandparents from both sides of his family who had also been THs. TH2 did not share information about his training experiences.

THs 1 and 3 were contacted through storefront advertising in urban Western Cape Town. TH3 was referred through established networks with Afrikaans oncology nurses and collaborating mental health professionals.

Research design

Qualitative descriptive research was employed for the purposes of this

study. According to Sandelowski (2000), qualitative description strives to capture the 'who, what, and where' of the phenomenon under study. Since little is known about how THs treat patients with BCL, this design allowed for the exploration of ways in which South African THs manage BCL and educate their patients about the condition.

Data collection

Interviews with THs were conducted with a semi-structured, open-ended interview adapted from a guide previously used with patients and practitioners in the USA. Questions on the tool address general health beliefs and BCL management. The interviews were held by pre-arranged appointment with THs 1 and 2 in their storefronts/offices; TH3 in his home; and THs 1, 2, and 3 in their treatment rooms, as appropriate and according to the TH's preference. In the interviews with all three THs, one to four additional members of the research team were present in addition to the principal investigator/interviewer. Interview appointments with TH3 were made some days ahead through the local community contact persons, whereas the interview with TH1 and 2 took place by their choice on the day of the initial meeting. The interviews, which lasted 1–2 hours, were conducted by a researcher trained in qualitative interview techniques and familiar with the interview techniques using the adapted guide. Interviews were audiotaped with permission, transcribed verbatim by two trained members of the research team, and checked for accuracy. Photographs and field notes were also taken (Figures 1 and 2).

Data analysis

Transcripts were maintained in three separate documents and were reviewed independently by two trained members of the research team. Each transcript was reviewed multiple times to identify common themes. The transcripts were then reviewed again to capture comments that illustrated the identified themes (Polit and Beck, 2008). These themes and comments were reviewed and edited by two other members of the research team.



Figure 1. TH3 at his home during the interview.

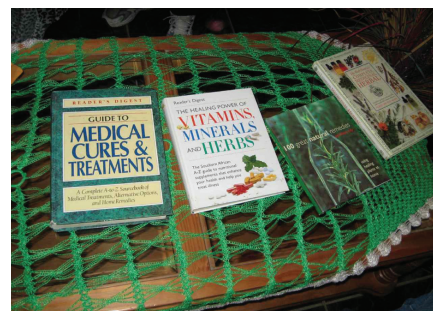


Figure 2. Resources used by TH3 for continuing education.

Findings

Themes were finalised by the entire research team. Five main themes emerged from the data:

- ▶▶ Folk medicine training
- ▶▶ Multidisciplinary collaboration
- ▶▶ Perceptions of cancer
- ▶▶ Disease characteristics
- ▶▶ Disease management.

Folk medicine training

The THs described different forms of folk medicine training reflecting a variety of experiences. TH2 explained that training was learnt from cultural practices: 'Well, I was brought up in a culture that translates all the many herbs. People in that culture... will just tell you what kind of flower to boil and drink, something like that...' TH1 echoed similar experiences. TH1 recounted how training was passed down from generation to generation:



Figure 3. Different herbs used in the three-step treatment regimen by TH3.

'Learned from the bushmen who have known of medicinal properties of plants for generations'. TH3 stated the ability to practice as a healer was a gift: 'This is a gift. This is not a choice... So it came to me by dreams. I dreamed a lot... Even if the, the path, the way from where I lived at that time to that particular place because that place was unknown to me at that particular time. Yes. And I was told everything about the person I was going to get training from.' Learning from books about herbs, their uses, and their properties was part of his learning: 'And do you know what I have something like herbal books just to assist my knowledge because you, you must have an ongoing learning.'

Perceptions of cancer

A second theme emerging from the data dealt with different perceptions of cancer among the THs. TH1 noted cancer could be accompanied by spiritual problems, which needed to be addressed before Western medical treatment could be started: 'Sometimes, the patient is not only dealing with cancer, but there is a spiritual problem. We take care of that and then send them back to you and they are healed. The interference makes the medicine take longer to work, but it's working, but the effects are blocked by the negativity so that the person can't receive the treatment. We make them fit enough to receive treatment'.

TH2 equated cancer with a death sentence and compared cancer with AIDS: 'Cancer is like AIDS. You really have to die.' Similar to TH2, TH3 noted cancer was stigmatised like HIV: 'Do you know cancer disease has got a stigma

like HIV? Because other people can think that.' According to TH3, cancer was perceived as a foreign disease: 'The cancer is not an African disease. It's another world's disease. So that is where the patient got discouraged. This patient might hide because of the stigma of the disease.' TH2 also believed cancer was a dangerous disease: 'Well when it comes to the body... the skin and the body, they are things that speak for the human being like if there is something wrong in the body. You got to see it from the outside... Different things will change every day. Somebody hides something like cancer or a dangerous disease like that maybe that will show.'

Multidisciplinary collaboration

A third theme drawn from the data dealt with multidisciplinary collaboration between THs and WMPs. These collaborations manifested in many forms. In one respect, collaboration was conducted as a one-way referral basis from TH to WMP. According to TH1, working with WMPs occurred when traditional healing was unsuccessful: 'A woman came to him for help with a breast lump and he tried to treat it, but it advanced (got harder) so he sent her to a Western hospital because he knew it was important that it be seen as early as possible'. TH1 indicated collaboration involved direct oversight from a physician while providing care: 'In Kenya I worked closely with doctors in hospitals to treat patients and if approved an alchemist would prepare the herbal remedy for the patients'.

TH3 suggested collaboration was a dynamic relationship based on mutual respect between the TH and WMP: 'We work hand in hand with the clinic sisters [nurses]. If they might see something they don't understand, they are to send those people then to me, and I am able to send those I don't understand here to the clinic. So we interrelate. We share information of the patient in terms of the patient's life also, and we want to keep, we want to restore the life of the patient.' TH and WMP shared a common goal in caring for the patient. TH3 described this goal in terms of determining the best possible treatment for the patient by collaborating with

WMPs: 'Most people understand that, oh, there is co-operation between the two because I like to advise my patients what is important is your problem. What is not important is where you get your; your problem erased or wiped away. It can be wiped away by a traditional healer or a prophet or a clinic or a medical practitioner. So if I say, how if you start like this so I will come away fully aware that you are at peace, that patient agrees to do that because that patient understands that the very important thing is his own life. And by sending him or her to another type of facility, it's just to, to verify illness and see or find a way that I, that he, can get help of.'

Finally, TH3 suggested collaboration resulted in educational opportunities: 'We improve knowledge of different illnesses. We used to have professors from cancer unit. If we want to know something about cancer, then we invite professors from cancer unit in hospital. Sometimes we invite them to advise us about cancer of the eyes or cancer of the brain. It depends that particular year which topic do we choose.' Overall, collaboration involved working with WMPs in different capacities.

Disease characteristics

TH1 characterised cancer and cancer-related illness in terms of physical and psychological manifestations: 'Most often spiritual problems manifest itself as physical/psychological'. THs 2 and 3 indicated external visualisation of symptoms comprised important assessment criteria. TH2 observed: 'Well when it comes to the body... the skin and the body, they are things that speak for the human being like if there is something wrong in the body. You got to see it from the outside...'. Similarly, TH3 remarked: 'Swellings, lumps in the, in the breast areas or in the testicles if a person is a man. Yeah, those are the most symptoms patients come in with when they come to us.'

Cancer was also characterised as an illness that could not be disguised or camouflaged and would eventually become visible to others. TH2 stated: 'Different things will change every day.

Somebody hides something like cancer or a dangerous disease like that maybe that will show.' Disease manifestations were observed to change and progressively become more apparent, implying TH2 believed cancer to evolve over time.

TH3 identified common physical symptoms presented by patients with breast cancer or testicular cancer, including breast and testicular lumps, respectively. However, it was unclear if TH3 characterised swelling in terms of palpable/visible breast tumours or swelling of the limb as a result of BCL pathology. An important initial step in forming collaborative relationships between THs and WMPs will be to determine ways to improve communication about BCL and cancer-related illnesses to ensure discussion about illness is understood and characterised in the same manner.

Disease management

Spiritual guidance and personal choice play an important role in determining the course of treatment for cancer and BCL. According to TH1, a spiritual force selects the healer from whom the person with illness seeks treatment: 'First consult your god or who you believe in and ask for help, then they will send you to who they want... if a patient comes — nobody comes here unless his ancestors ask our ancestors for help. Everything happens in the beyond'.

Lifestyle preferences direct care once the selection of a healer has been made. Individuals who seek treatment potentially already know how to manage their symptoms upon visiting the TH: 'Because maybe our patients will already know how, with them, what to provide for different kinds of symptoms.' This observation suggests a collaborative relationship exists between the TH and the patient in determining care. For example, TH2 observed a vegetarian would not receive the same nutritional advice as an individual who eats meat, thereby reflecting individualisation of care to patient preferences: 'Well different kind of people on purpose are brought up on different kinds of foods... it depends

on what you're giving him... If someone is a vegetarian you can't expect them to have stuff like food like meat.'

However, the incorporation of certain foods into dietary selections was stressed to enhance treatment. TH3 observed the importance of pork and vegetables in facilitating the effects of medication: 'Do you know if a person is sick or ill, the very, the nutrition itself, we might encourage some of the things to eat. Like a pork. Our medications need a lot of pork if a person is suffering from cancer. Because we believe that the fat of the pork can fight the increase of the illness in the body. From there it's vegetable, all kinds of vegetables. Yes. Except medicines, the other part is nutrition.'

Medication regimens specific to the management of BCL included ingestion of drinkable mixtures, bathing with herbal powders (Figure 3), and applying herbal ointments directly to the affected area on the skin: 'So what happens is that if a person with cancer comes to me, I give him or her treatment. The treatment that we use is drinking mixtures, mixtures that you to, to drink, that are drinkable. Secondly, we use something like a washing powder. We make herbal washing powders that they put in the water when they bathe. Thirdly, we give them ointments, herbal ointments. Yes. To, to cover the place that is affected... Yes, it helps a lot to decrease the swelling. And others, they get cured already if they use this three-step treatment'. This treatment regimen was utilised to reduce swelling and potentially cure BCL according to TH3. While the THs were reluctant to reveal the specific herbs used in their practice, they believed their treatments had a therapeutic effect.

Discussion

Commensurate with the findings of Shai-Mahoko (1996), THs treated a multitude of illnesses in their communities. Physical and spiritual health assessments and metaphysical and herbal interventions were routinely incorporated into practice. Although these practices are not widely recognised by WMPs, the

common objective of providing care that best meets patients' needs must be emphasised in creating a collaborative and reciprocal relationship between THs and WMPs in order to gain the trust of the people and respect the diverse cultural beliefs in the community.

An additional shared characteristic includes a desire to provide up-to-date care through lifelong learning. Evidence-based practice is a cornerstone of the Western medical model of care. TH3 indicated a similar need for THs to continue to update their knowledge and skills by reading literature relevant to practice, sharing practice experiences with other THs, and attending conferences and seminars. Moreover, THs and WMPs can be professionally enriched if they are willing to explore healthcare practices that are different to what they are accustomed to using in everyday practice. This exploration holds the potential to help address gaps in the knowledge.

For example, TH3 stated THs can identify symptoms but often do not understand the cause of the symptoms. WMPs could share their perspectives on the aetiology of different illnesses, including BCL. Reciprocally, THs can help WMPs understand the importance of traditional medicine in addressing health conditions. For example, *moriti wa letswele*, translated as 'the shadow of the breast' fits the profile of somatoform pain disorder according to the DSM-IV (Mogale, 1999). Although WMPs attempted to treat this illness in accordance with the DSM-IV profile, patients were unresponsive to care. Only treatment provided by THs with a herbal ointment relieved the symptoms (Mogale, 1999).

However, WMPs must be sensitive to non-standardised care practices, as THs enter the field through different training programmes and often have more than one area of specialty. Moreover, THs and WMPs must be willing to learn from each other in order to enrich practice. This will help with the referral and networking processes as THs and WMPs will have contacts in each other's fields for patient referral and have an identified

potential collaborator. Because BCL is not a commonly recognised condition in South Africa, the need for collaboration between THs and WMPs is especially acute. Collaboration will promote earlier identification of individuals with BCL and help patients access the care they need.

de Andrade and Ross (2005) studied ways in which South African THs managed hearing loss. The researchers indicated an increased need for collaboration between THs and audiologists. This resulted in enhancing mutual referrals as well as helping to incorporate THs in care provision. Findings from this study complement the recommendations we have made in developing a synergy model for providing care to patients with BCL.

The synergy model reflects the merging of Western and folk medical practices in order to provide optimal care to individuals affected by BCL and other cancer-related health deficits. Synergy results when the product of collaboration between multiple entities is greater than the sum of its parts. By synergising care between THs and WMPs, care will be improved for people with BCL. Emphasising the common goal of providing the best care to the patients they serve can initiate dialogue between THs and WMPs as they seek ways to integrate care practices. Development of an educational module for THs based on this model and our understanding of traditional medical practices in management of BCL and other cancer-related conditions provide a starting place for collaborative management of South African patients with BCL.

Limitations

Several limitations manifested over the course of the study. While there are female THs, only three male participants were recruited, which resulted in a small, gender-homogenous sample. An additional limitation was that the participants possessed diverse training and practice experiences, which complicates describing the practice of a typical TH. Prolonged engagement was limited, as participants were interviewed only once. There was also a language barrier as English was not

the primary language of the participants and there were cultural differences that were potentially confounding. For future studies, the authors recommend carrying out multiple interviews with both male and female THs over an extended period of time in order to enhance dependability and credibility, as well as establishing trust and rapport with participants.

Conclusion

THs' reported activities that support the early stages of a dynamic and complementary relationship between THs and WMPs for the care of patients with BCL in South Africa. Based on the analysis of the interviews, it is evident that there is a need for increased collaboration between THs and WMPs concerning the management of BCL. Based on the proposed concept of synergy, the authors have several recommendations for future research:

- ▶ Understand THs' contribution to patient care and identify common ground with WMPs
- ▶ Learn and understand practices of THs concerning management and treatment of lymphoedema
- ▶ Understand traditional healers' wishes to learn about Western medicine and effective care of BCL and other cancer-related health deficits such as the lack of understanding in the exact causes of cancer as expressed by TH3.

Developing a synergistic model of best practice has the potential to integrate both Western medicine and traditional healing. This model will perhaps best be utilised to provide the framework for educational health programmes for both WMPs and THs. Optimisation of patient-centred care through integration of Western medicine and traditional healing would be the ultimate goal of such a programme. **JL**

References

American Cancer Society (2009) *Lymphedema: What every woman with breast cancer should know*. American Cancer Society, Atlanta Available online at: www.cancer.org/docroot/MIT/content/MIT_7_2x

[Lymphedema and Breast Cancer.asp](#) [Last accessed 23 March, 2009]

American Cancer Society (2006). *Lymphedema: Understanding and Managing Lymphedema After Cancer Treatment*. American Cancer Society, Atlanta

Brennan MJ, Weitz J (1992) Lymphedema 30 years after radical mastectomy. *Am J Phys Med Rehab* 26: 265–81

de Andrade V, Ross E (2005) Beliefs and practices of Black South African traditional healers regarding hearing impairment. *Int J Audiol* 44(9): 489–99

Mogale CC (1999) 'Moriti wa letswele' (The shadow of the breast) — A stress-related somatoform pain disorder. *S Afr J Psychol* 29(2): 72–5

Mqoqi N, Kellett P, Sitas F, Jula M (2004) Incidence of histologically diagnosed cancer in South Africa, 1998–1999. National Cancer Registry of South Africa, National Health Laboratory Service, Johannesburg. Available online at: www.nhls.ac.za/Updated%20cancer98_ALL.pdf [Last accessed 2nd December, 2008]

Peu MD, Troskie R, Hattingh SP (2001). The attitude of community health nurses towards intergration of traditional healers in primary health care in North-West Province. *Curationis* 24(3): 49–55

Polit DF, Beck CT (2008) *Nursing Research: Generating and assessing evidence for nursing practice*. 8th edn. Wolters Kluwer, New York

Sandelowski M (2000) Focus on research methods: Whatever happened to qualitative description? *Res Nurs Health* 23: 334–40

Shai-Mahoko SN (1996) Indigenous healers in the North West Province: A survey of their clinical activities in health care in the rural areas. *Curationis* 19(4): 31–4

South African Ministry of Health (1999) October is breast cancer awareness month. Available online at: www.doh.gov.za/docs/pr/2001/pr1001.html [Last accessed 12th November, 2008]

South African Government (2008). Traditional medicine. Available online at: www.info.gov.za/aboutsa/health.htm#Traditional [Last accessed 12th November, 2008]

South African PET Users Association (n.d.) Predicted demand for PET services in South Africa. Available online at: www.sasnm.com/National_Strategy_Discussion_Document_final.pdf [Last accessed 9th March, 2009]

World Health Organization (2009) Traditional medicine. WHO, Geneva. Available online at: www.who.int/medicines/areas/traditional/en/index.html [Last accessed 23rd February, 2009]