Health and Disease

SOME TOPICAL PROBLEMS OF SOCIOCULTURAL TRANSITION

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SUMMARY

A brief sociological sketch of our current understanding of the social structure among Blacks is presented, with a decided emphasis on its historical link with pre-industrial Black ontology, a concept to be explained later in this discussion. A serious attempt is made through phenomenological analysis to deal with the now well-known resilience of traditional ideas in the areas of health and disease.

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The peculiarities of Black societies as distinct from those of Western European descent have been a stock theme of cultural anthropologists, novelists, explorer-adventurers, missionaries and others. As late as the last decade, we find in South Africa such devout cultural propagandists as Bryant[1] and Silberbauer.[2] Regrettably we find on examination that the innocent conceit of the early observers of the last and early 20th centuries are still present in the 7th decade of the present century, in spite of the unprecedented sociocultural changes which have been witnessed on the African continent.

Silberbauer and others are guilty of a strange misconception, namely that they write and talk as though the sociocultural status of Blacks is static. This last issue is of considerable importance and is one which requires the most dispassionate type of analysis. The areas of concern of this paper may be described as follows.

THE DESCENT OF TRIBAL MAN

The present century is possibly seeing the last vestiges of so-called traditional societies in Africa. One of the symptoms of the wide-ranging changes of the times is the disrepute into which the concept of the tribe has fallen.[3] According to Uchendu[4] several varieties of man in Africa have been described in the literature ('primitive man', 'detribalised man', 'the attention-getting elites' and the 'transitional or developing man'). In the light of the general transformation of African societies, what may be said about the transformation of the Black man in South Africa?

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Pre-industrial African Ontology

In view of our concern with ideas relating to health and disease we have to introduce our discussion of the kinds of changes which have occurred in South Africa's Blacks by considering, however briefly, pre-industrial Black ontology.

An understanding of Black ontology — the Black man's philosophy of being, his philosophy of existence (life) — is fundamental to a fuller appreciation of his ideas in the areas of health and disease. This philosophy of existence (ontology) has been forcefully documented by Tempels.[5] In a later statement, Senghor[6] gives the following brief but comprehensive description of the Black man's world view:

'Like others, more than others, he distinguishes the pebble from the plant, the plant from the animal, the animal from man; but, once again, the accidents and appearances that differentiate these kingdoms only illustrate different aspects of the same reality. This reality is being in the ontological sense of the word, and it is life force. For the African, matter in the sense the European understands it, is only a system of signs which translates the single reality of the universe: being which is spirit, which is life force. Thus, the whole universe appears as an infinitely small, and at the same time an infinitely large, network of life forces which emanate from God and end in God, who is the source of all life forces. It is He who vitalises and devitalises all other beings, all other life forces.'

African ontology, therefore, conceives of reality as consisting of interdependent, interacting life forces. These life forces, which are not of the same magnitude or potency, are organised according to a principle of hierarchy of prepotency. Depending on an individual's social and other circumstances, his life force (vital force) could be vitalised or devitalised, increased or decreased. He could, as it were, be healthy or ill. The aetiology of his decreased vital force is to be searched for and understood in relation to his existential relations with other vital (life) forces in his physicosocial environment. Is this ontology still valid? An attempt will be made at a later stage to deal with this question more fully.

Sociological Perspective

In order to answer our question relating to the current validity of African ontology, it is necessary to address ourselves to some of the current sociological evidence relating to the urbanisation and industrialisation of Blacks in South Africa.

According to current historical evidence, the first recorded historical contact between Blacks and Whites was

during the year 1770 on the banks of the Great Fish River. Since that year, closer contact has been brought about by industrialisation and urbanisation. The trend in urbanisation may be observed in figures provided by Moolman[7] in the following table.

URBANISED POPULATION IN SOUTH AFRICA (PERCENTAGE)

Year	Whites	Blacks*
1904	—	**10**
1911	**53**	**13**
1921	**60**	**14**
1936	**68**	**19**
1946	**77**	**24**
1951	**79**	**28**
1960	**84**	**32**
1970	**±86(?)**	**55**

* Note that Moolman used the term 'Bantu'.

Moolman's figures reveal that 55% of the Black population was in South Africa's urban areas in 1970. If one concedes that the Black population is much larger than the White population, it is immediately evident that there is a significant Black population in the urban areas.

It is not sufficient to observe that these Blacks have been exposed to urbanisation and industrialisation since the turn of the century. We need to have more systematic formulations of the kinds of psychosocial changes which have taken place since the turn of the present century. A number of outstanding observers have made contributions relevant to the problem of social change among Blacks.[8-15] What insight can we gain from these contributions? Let us examine some of the more important formulations in this respect.

We begin with the reports of Wilson.[14] Her studies in the Cape Peninsula led her to the conclusion that the people of Langa (a Black residential area) classified themselves into the following categories: (*a*) townsmen ('decent people' and 'tsotsis'); (*b*) Migrants (*amagoduka, amaqaba*); (*c*) *Iibari* (usually residing and working in flats). She also found that there were several distinct social groups: families, home-boy cliques, church groups and various clubs (sport clubs; savings circles, etc).

Mayer,[8] in his comprehensive studies of East London, found the following basic social categories: 'real townspeople', 'red migrants' and 'school migrants'. Houghton,[16] in his contribution, recognises the existence of three categories of workers from traditional societies. These are the 'emigrant breadwinners' who are in the urban areas to work and make money so as to be able to support their families in the rural areas. The 'emigrant families' are composed of those workers who have migrated to the towns lock, stock and barrel. The third group, the 'absconders' (*makholwa*) are those who have no commitment to anybody either in the rural areas or in the town.

Regional urban differences are always to be expected in view of the differences in ethnic group composition. In this respect, for example, Soweto (Johannesburg) would differ markedly from the East London residential areas studied by Mayer. In spite of this consideration, it is probably true to say that the findings relating to social categories and social groups have a wide area of generality.

To complete our brief sociological review, it is necessary to pay attention to two additional aspects. First there exists the general question of the status of Black intensive population areas in the cities. Any urban area of reasonable size in South Africa has a White city area and a Black residential area (location or township) as part of its ecological structure. The basic characteristic of these satellite communities is that in important respects they are neither urban nor industrial, since their economic viability is entirely dependent on the White cities. Neither could they, strictly speaking, be compared with suburbia. Lambo[17] has pointed out that in their psychosocial characteristics these communities are to be identified with (*a*) an unusually high morbidity rate (social pathology); (*b*) 'non-traditional' and 'non-supportive' child-rearing practices; and (*c*) the absence of community support during periods of stress. Referring to Soweto, Helleman[13] has also made some observations relating to changes in social structure. In her view, the main changes have been in the areas of the extended kinship system, the patriarchal family structure and the emergence of the nuclear family. The scope of the present paper does not permit an extended treatment of Black urban and other sociology, although it could be interesting, for example, to look at social mobility in these groups, but that is another matter. We planned to limit our analysis to those aspects of Black urban sociology which were considered to be related to the central theme of this paper, namely ideas of health and disease.

TRIBAL AND WESTERN MEDICINE — CONFLICT OR SYNTHESIS?

The study of ideas of health and disease among Blacks has since passed the stage of satisfying the curiosity of foreign observers to more well-formulated and serious attempts such as those of Maclean[18] and Read.[19] Significant recent efforts in this country are those of Fisher and Hurst[20] and Hurst *et al.*[21] Anecdotal evidence abounds to suggest that traditional methods of dealing with illness in the Black urban areas are still the rule rather than the exception. For example, Hurst *et al.*[21] have suggested that they recognised a shift in their sample from magical explanations and witchcraft towards Western ideas of causation and treatment.

Blacks here and elsewhere may be classified into three categories on the basis of their response to the introduction of Western medical services. Firstly, there is a group of traditionalists, possibly now the smallest group, who will only use traditional medical services. The second group consists of those who will use Western services to the total exclusion of all other services. The third group, possibly the biggest group, consists of those who will use a combination of traditional and Western services.

Our analysis may now be crystallised to lead to two related observations. The first of these observations amounts to saying that available sociological evidence from studies in various urban areas in South Africa reveals that there are several recognisable social categories (townsmen, unschooled migrants and schooled migrants) or, more briefly, emigrants and migrants. The evidence also suggests that the migrants such as the 'red' migrants of East

London or the *amaqaba* of Langa, Cape Town, may remain 'encapsulated', insulated from the more significant urban and industrial influences. In this respect, it should be noted that an increasing number of Blacks are being exposed to urban industrial environments for varying periods of time (55% in 1970).

The second observation: what accounts for the observed resilience of traditional views and practices in the areas of health and disease? This question, important though it is, has not been treated with the seriousness that it deserves. It is my submission that this question may only be adequately understood and formulated through a phenomenological frame of reference. This means that we must attempt to understand the Black man's perception of being-in-society (being-in-the-world); his mode of experiencing his phenomenal field; his experience.

A phenomenological exercise of the type suggested will lead us first to a recognition of the current validity of African ontology (the theory of forces) as an organising principle in the lives of the 'red' migrants (the *amaqaba*), the *Iibari*, the home-boy cliques and other urban non-kinship-orientated associations.

In the case of these groups who constitute the bulk of our urban Black proletariat, no other subjective experience of being-in-the-world, no other organising principle has overtaken that of the theory of forces. No competing world-view exists for these people. If and when Western ideas are opportunistically utilised, they are subjectively being experienced within the framework of the theory of vital forces; of African ontology. No contradiction or conflict is involved, but only a situation synthesis.

What of the townsmen? Why is it that even in their case we invariably find a sporadic return to African ontology — the usual combination of Western medicine and traditional remedies? In my view, this sociocultural regression is proportionately related to the degree of stress experienced by the individual or his family. Phenomenological analysis tells us that in these cases, too, we are probably dealing with a competition of world-views, of ontologies. It is not difficult to see that African ontology has a decided historicocultural advantage in terms of formative influence over Western conceptions derived from a dominant White culture.

Our analysis tells us further that the theory of the resilience of traditional beliefs, which is based entirely on a defence mechanism hypothesis — which understands the Black man's behaviour to constitute a security operation — does not constitute the whole story. It seems to me that while the principle of situational relevance accounts for a considerable part of the behaviour, it is necessary to suggest that African ontology as an organising principle in certain classes of urban Blacks (townsmen) has become dissociated (not repressed) from the self-system, and remains latent as long as stress is subliminal, only to be activated the moment the stress is beyond a certain threshold.

On following the phenomenological line of analysis I arrive at the conclusion that Mayer's concept of 'encapsulation' in respect of the East London 'red' migrants does not do justice to the psychosocial reality to which it is a reference. It seems to me that the current structure of South African society or that of the history of any contact situation between White and Black has had deliberate, planned and religiously guarded encapsulation as its dominant characteristic. This fact is one which is subject to easy demonstration by invoking the limitations on cultural diffusion created by legislation and the resultant categorical types of sociocultural interaction characterised by stereotyping as well as the existence of religiously graduated opportunities for assimilation of other sociocultural alternatives.

IMPLICATIONS

There are several implications which flow from this analysis. These will be briefly stated.

Current evidence suggests that what we are witnessing in the area of health is not a conflict between Western medical practices and traditional ones. Analysis favours a view which suggests a psychosocial synthesis which is understandable and not to be scoffed at.

Health programmes of whatever description are relevant to the extent that they are related to the needs of the patient-community they serve and not otherwise. Since this is not controversial, it should come as no surprise that health programmes should be based on a solid and sound psychosociological knowledge of the specific communities involved.

As I have said elsewhere, a solid sociology is mandatory in the planning of training programmes for health personnel and will determine to a large extent the degree to which treatment modalities became relevant to specific human situations.

Finally, I would like to say with all the conviction at my command, that the witchcraft extravagance which has characterised the many contributions of some competent observers, is quickly becoming museum material and must be replaced by a relevant and enlightened sociology, anthropology and sociopsychology.

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