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Proceedings  
of the  
Second International Congress  
of Somali Studies

University of Hamburg  
August 1-6, 1983

*edited by*  
*Thomas Labahn*

— VOLUME IV —

STUDIES  
IN HUMANITIES  
AND NATURAL SCIENCES

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SCIENTIFIC MEDICINE VERSUS TRADITIONAL MEDICINE?  
REFLECTIONS ON THREE YEARS' EXPERIENCE IN A SOMALI  
VILLAGE

Introduction

It is a common experience of people who dedicate themselves to improve the education and health of peoples living in developing countries, especially those living in remote areas under tribal or semi-tribal conditions, to be often disappointed as far as long-term results are concerned. One United Nations' expert who has worked in the field of adult education in several countries recounts:

"While working, twenty-five years ago, in an internationally assisted Fundamental Education Programme in Somalia, we introduced to some villagers a more efficient potters' wheel than that which they were using. The craftsmen learned very quickly how to use the new tool. They thanked us sincerely for our help and promised that, although they did not intend to use the new wheel, if we just give them a day's notice of the arrival of any United Nations visitors, in order to show their gratitude they would pull it out from the corner and demonstrate their ability to use it.

The explanation of this surprising announcement was quite reasonable; they had no need to produce pottery more efficiently than they had been doing.

The programme was neither needed nor expected by them. It was carried out simply because funds had been allocated for it.

Fabula docet: do not teach new practices before the people are so motivated to seek them, for your action, if not wanted, will fail." (Bonanni 1982)

I have had the opportunity to hear similar stories told by doctors and nurses working in other countries as well. In a

paper presented at a symposium on health and disease in tribal societies, held in London in 1976, I. M. White (1977) underlined that among Australian aborigenes living under semi-tribal conditions, recent improvements in health, though considerable, had not been commensurate with the greatly increased expenditure on health and welfare services.

In view of so much scepticism, I decided to review critically the obstacles encountered by my collaborators and myself during a recent project among farming villages along the Shabelle river in the Lower Shabelle region in Somalia. This experience was part of an educational process in community health for the medical students of the Faculty of Medicine of the Somali National University (Tresalti/Ibrahim 1979).

#### An Educational Pilot Project of Community Health

Beled Amin is a village which, in 1978, had a population of 1103 inhabitants. It is situated in the Afgoy district of the Lower Shabelle region, 18 km from Afgoy on the left bank of the Shabelle river.

It is accessible on dirt roads, except during the rainy season when the few river boats are often the only transportation.

Out of 1103 inhabitants, 41% were under 15 years of age. Although there is a primary school, 50% of people over 10 are illiterate. Seven satellite villages, with a total population of about 900, depend socially, economically, and administratively on Beled Amin. All these villages lie on the other side of the river and can be reached on a hand-pulled ferry. The children in these villages have to go to Beled Amin in order to attend primary school, walking 30 to 120 minutes.

Women (the population is 51% female) work both at home, cooking and cleaning house, and in the fields; they transport the products of the soil, and provide water, by carrying traditional containers on their backs or tied to their heads.

We have no figures on miscarriages and problems in deliveries, but it seems that fetal-pelvic disproportion is not infrequent. We know that pelvic deformity can occur from the combination of malnutrition and carrying heavy weights on the back or the head. The traumatic practice of female circumcision is widely performed in Beled Amin. Deliveries are attended by several elderly untrained Traditional Birth Attendants (TBA).

Most of the men have one family in a single house; some of them have more than one family in the same house, and some have one or two other families in other villages. We could not obtain figures about divorces, but we observed that they are very frequent. The main causes seem to be infertility and repugnant (and supposedly incurable) gynecological diseases, e.g. vesicico-vaginal fistula, due to bad obstetrical care.

Nearly all the inhabitants are farmers. Some work on co-operative farms while others work for wages on state or public agency farms.

All houses in Beled Amin are traditional. Their inhabitants defecate in the surrounding bush, with a consequent high degree of environmental pollution. During the dry season the continuous blowing of the wind raises large amounts of dust and sand, so that people live in an unceasing dusty atmosphere. During and after the rainy season, and also due to occasional dry season flooding, many temporary bodies of water surround the villages. These constitute breeding sites for mosquitoes and a suitable habitat for many snails, including *Bulinus abyssinicus*, the intermediate host of *Schistosoma haematobium*.

Beled Amin people are very religious. The mosque is the only building made of stone and many sheikhs have a deep influence on their people. This religious attitude also affects health problems; intervention of the sheikh for healing purposes is often required, and he successfully cures many illnesses. There are also traditional healers who heal by using burnings, and witch doctors ("bahar") who use both

medical herbs and magic practices.

Medical facilities were nonexistent in Beled Aamin before our intervention; not even surveys by WHO sponsored projects had been made previously. Sick people had to go to Afgoy by collective taxi in the dry seasons, or walk the 18 km during the rainy seasons, in order to get nursing or medical assistance or simply for drugs. Certain medicines were also often sold in small drugstores in the village.

About 40% of the population harbors urinary schistosomiasis and 20% suffer from malaria. A rough assessment of the infantile mortality rate yielded a result of 200 per 1000; tuberculosis, intestinal parasites and malnutrition are very widespread.

Our involvement in Beled Aamin was aimed at initiating preventive and curative medical help for the small population of this village and to provide realistic field training for the medical students.

From the beginning of our work we tried to get in touch with all the authorities: civic, religious, and traditional.

A council of five members, to which are joined the chiefs of the satellite villages, presided over by the president ("guddomiya") represent the local civic authority. They were our point of references for any kind of activity in the village.

We did not contact the religious authorities directly but we always respected them and the religious feelings of the people; we also helped to repair the mosque. We tried to get in touch with the witch doctors and traditional healers from the outset but, because of various social and cultural barriers stemming from past poor relations of the "bahar" with the authorities, we did not succeed immediately. Only after a year of our presence did we begin to be able to talk with them.

The first year of our presence in the village was dedicated to meeting and getting acquainted with the people and to

collecting data on vital statistics and morbidity. At the same time we started a bi-weekly out-patient clinic in order to give them a regular and understandable reason for our presence and to help them in their daily health problems.

#### Attitudinal Problems on both Sides

The main attitudinal problems of the students during this first period were:

- a preference for curing illness rather than encouraging good health - the easier but less effective approach;
- little attempt to communicate with patients, laughing at their pronunciation and their use of regionalisms different from the "pure" Somali language which many of the students coming from different regions were speaking;
- directing patients to carry out procedures impossible for them to perform under the actual conditions of life in the village;
- a tendency to ridicule attitudes and beliefs of the villagers about health and disease, treating them as "primitive superstitions" and treating the medicine man with contempt, rather than trying to integrate the two systems and to work with the medicine men and midwives;
- students believed too strongly that medical measures alone would bring those people's health up to town standards. They failed to realize that health problems arise more from low socio-economic status, from poor housing, from inadequate water supply, and education than lack of health care.

We succeeded, at least partially, in changing these attitudes. It was particularly fruitful when in 1979 a group of ten students tutored by an assistant professor spent one month in the medical center of Beled Aamin. The students had to share the daily life of the villagers and thus learned to face their problems in a realistic way.

The villagers, on the other hand, had their own prejudices which slowed our activity. They tended to take a passive attitude, wishing we would build them a nice brick hospital or simply offer them drugs rather than encouraging their participation in preventive measures. Many times the villagers took medicines without understanding its implications and viewed advice given by doctors and students as irrational.

#### A Tentative Evaluation

Two years after the onset, and one year after the beginning of preventive intervention in Beled Aamin, we tried to make a rough evaluation of the attitude of the people toward traditional and scientific medicine to find out if there had been any changes in this attitude.

During that period in Beled Aamin there were two traditional healers and one sheikh interested in treating patients.

We interviewed the members of the council, patients attending the out-patient clinic, the two traditional healers themselves, patients attending the traditional healers' clinic and, randomly, people on the street.

All the persons interviewed agreed that after the arrival of the university doctors there was less sickness than in the past.

In cases of acute illness with fever, the villagers' first choice is now the doctor. In the so-called wind illnesses, i.e. psycho-somatic and mental diseases, the first choice is the "bahar"; the same is true for anemia ("buo-buo"), which is self-diagnosed when the patient feels run down. When talismans are wanted against the evil eye or in cases of headache, the first choice seems to be the sheikh. For pain, the first choice is the traditional burn healer.

In any case, if the first choice does not give a satisfactory solution to the problem, a different type of practitioner is

consulted for a second opinion.

One negative aspect of scientific medicine is seen as the lack of privacy and the long queue. Some people who say they trust the doctor do not go to the clinic because they anticipate so many people waiting to be seen; they therefore decide that Allah will cure them.

The "bahars" agreed that their work was declining, but, they added, they were all becoming old.

#### Impact of "Scientific" Medicine

I wish to point out here the results of the impact of "scientific" medicine represented by the medical students on the villagers. According to my experience, community health approach cannot be efficacious without a proper appreciation and actually intelligent integration of traditional medicine.

In order to make a healthy integration, the following requisites are needed:

- an attitude of deep respect for the "old" which has to be considered not in a sacred way but as the result of the feelings and experience of many men and women according to their knowledge and interpretation of the life;
- an attitude of research, i.e. our approach should not be as if we were the only owners of the truth and of the good, but we should be ready to learn from traditions and to accept a change of our truth. This attitude of research should concern both the reality we want to modify and our tools of action;
- these two previous attitudes constitute the ground of the scientific attitude.

We have to be fully convinced of the relativity of the value of scientific medicine and not an absolute one. Science cannot be an object of faith but only be considered as far as our present knowledge is concerned;

- in order to be effective we have to involve "traditional" health people (healers, TBA, etc.) in a process of recycling.

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