THE ROLE OF INDIGENOUS HEALERS IN DISEASE PREVENTION AND HEALTH PROMOTION AMONG BLACK SOUTH AFRICANS: A CASE STUDY OF THE NORTH WEST PROVINCE

by

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JUNE 1997
DECLARATION

I declare that "The role of indigenous healers in disease prevention and health promotion among Black South Africans: A case study of the Northwest region" is my own work, and that all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

S.N. SHAI-MAHOKO
DEDICATION

This work is dedicated to Badimo ba ga-Shai: my grandfather Mokgona, my grandmother Mmantwa, my father, my late youngest sister Mmangata, and to all those men and women who dedicate their lives to the service of mankind through indigenous healing in an attempt to make health care accessible, available, and affordable to the people of South Africa.

A Lady Sangoma
SUMMARY

THE ROLE OF INDIGENOUS HEALERS in DISEASE PREVENTION and HEALTH PROMOTION AMONG BLACK SOUTH AFRICANS;
A CASE STUDY of the NORTHWEST PROVINCE

The majority of black South Africans utilize the services of indigenous healers and the new National Health Plan for South Africa makes provision for cooperation between the healers and formal health practitioners.

The purpose of this study was to determine the role played by indigenous African healers in the prevention of diseases and the promotion of health, and to design a model which will provide guidelines for cooperation between indigenous healers and formal health workers.

This study was ethno-medical, contextual, exploratory and qualitative. It was designed to look into the health care of a specific cultural group to explore in depth the experiences of indigenous healers in providing health care within their cultural context.

Data was collected by individual free-type interviews from indigenous African healers, users of formal health services and by observation.

It was found that there is dual utilization of both formal and indigenous health service systems by clients. A specific cultural terminology relating to health was found to be used. Such terminology could result in communication gaps and breakdowns if not known to or used by formal health workers.

The findings show that cultural beliefs are still strongly adhered to. These were found to influence the life-styles and health maintenance behaviour of a cultural group. The findings show that divination forms the core of health assessment and health-problem diagnosis. It was found that no health problem could be attended to without first going through a divination session.

The findings also show involvement of indigenous healers in primary health care workers at first contact levels of prevention in the field of paediatric preventive care. Diarrhoea and vomiting in children was found to be the preventable disease in which healers specialize. Infertility and impotence were found to be conditions taken to healers for treatment. Other sexually transmitted diseases as well as culture-bound syndromes treated by indigenous healers were found in this study. The use of rituals and rites of passage and the involvement of ancestors were found to form part of holistic health care.

The findings show the willingness of healers to collaborate with formal health workers. A model is designed to guide the process of collaboration.
Key terms:

Health promotion; disease prevention; primary health care; mental health; family well-being; acceptable health care; relevant health care; culture-bound syndromes; ethnocentric tendencies; cross-cultural health care.
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### Table of Contents

- **Declaration** ........................................................................................................ i
- **Dedication** ........................................................................................................ ii
- **Summary** ........................................................................................................ iii
- **Acknowledgements** .......................................................................................... v
- **Table of Contents** ............................................................................................ vi
- **Tables** ............................................................................................................... xiii
- **Figures** ........................................................................................................... xv
- **Annexures** ....................................................................................................... xvi
- **Definition of Terms** ......................................................................................... xvii

#### CHAPTER 1 : INTRODUCTION ..................................................................... 1

- **Historical Background to the Study** ............................................................... 1
  - Legal Control ................................................................................................. 1
    - The failure of formal medicine to provide adequate health care .................. 2
    - Moving towards an inclusive health care policy ....................................... 5

- **Statement of the Problem** .................................................................................. 6
  - The Present Situation ..................................................................................... 7

- **The Northwest Region: Background Information** ........................................ 9
  - Description of the Province ......................................................................... 9
  - Structure of health services ........................................................................ 9

- **Purpose of Study** .............................................................................................. 12

- **Significance of the Study** .................................................................................. 12

- **Research Model** .............................................................................................. 12
  - Paradigmatic view ......................................................................................... 14
  - Meta-theoretical assumptions ..................................................................... 14
  - Theoretical perspectives .............................................................................. 15

- **Research Question** ........................................................................................... 15
  - Basic Assumptions ......................................................................................... 15

- **Research Methodology** ................................................................................... 16
  - Research Design ............................................................................................. 16
  - Study Population (need more appropriate heading for this section) ........... 16
  - Sampling Procedures ..................................................................................... 16
CHAPTER 2: LITERATURE REVIEW

Introduction

Utilization of Indigenous Healers

Indigenous African Religious Views

African Religion

Modimo — The supernatural being

Badimo

Indigenous healers

The African World View of Life After Death

African Beliefs About Causes of Illness

Classification of causes of illness

Culture-bound syndromes

Mystical causes

Witchcraft causes

Impersonal causes

Maternal and Child Health Care

Preventive Health Care

Social Well-being

Mental Health Care

Culture-bound Syndromes

Summary

CHAPTER 3: Methodology

Introduction

Rationale

Research Design

Ethno-medical

Contextual

Exploratory

Qualitative

Population and Sampling Methods

Sampling procedures
Population and sampling methods ................................. 47
Sampling procedures ...................................................... 48
Selection of the regions .................................................. 47
Selection of healer sample .............................................. 48
Selection of user sample ............................................... 48
Selection of clinics ........................................................ 48
The Research Question .................................................. 49
Field Notes ..................................................................... 49
Pre-test .......................................................................... 49
Development of Research Instrument ............................. 50
Training of Research Assistants ..................................... 50
Ethical Considerations ................................................. 50
Sponsorship ................................................................ 50
Researchers/informant relationship ............................... 50
Informed consent ......................................................... 51
Purpose during first contact ........................................... 51
Collection of Data ............................................................ 51
Limitations of the Study ................................................. 52
Data Analysis ............................................................... 52
Quantification of Results .............................................. 53
Description of the Results ............................................ 53
Reliability .................................................................... 53
Validation of Data .......................................................... 54
Summary ........................................................................ 54

CHAPTER 4 : ANALYSIS of DATA ....................................... 55

Introduction .................................................................... 55
Terminology Related to Cultural Health Care .................... 55
Beliefs Related to Health Care ........................................ 57
Womanhood .................................................................. 57
Malignant Tumours (Cancer) ........................................ 58
Kokamo/Mogato ............................................................. 58
Sefi ............................................................................. 58
Sejeso ......................................................................... 58
Dikgaba .......................................................... 58
Analysis of Data ............................................................. 58

Domain Number 1: Patterns of Life-style of an Individual or Cultural Group ............................ 60
Sickness Behaviour ........................................................ 60
Health screening ........................................ 60
Treatment ........................................ 61
Relations between the ancestors and the living .... 61
Training ........................................ 61
Prevention of diseases and accidents ............. 61
Nutrition ........................................ 61

Domain Number 2: Cultural Norms, Values and Individual or Group Expressions in Relation to Health Care Behaviour 62

Cultural Healing Values ................................ 62
Prevention of Diseases and Promotion of Health 63
Family preventive measures ....................... 63
Prevention of diseases in children: .............. 63
Strengthening the body ............................ 63
Fortifying and cleansing homes and cattle posts 63
Drinking medicines for boswagadi .............. 63
Go tswa ka soba la mogodu .................... 63

Treatment of Diseases ................................ 63
Non-interference by Witchcraft .................. 63
Promotion of Physical and Mental Well-being 64

Cultural Healing Values ................................ 65
Prevention of diseases and promotion of health 65
Family preventive measures ....................... 65
Putting a baby on the floor ....................... 65
Lepakwana/mopakwana ........................... 65
Ditanyane ......................................... 65
Strengthening the body ............................ 65
Fortifying and cleansing homes and cattle posts 65
Drinking the herbs of boswagadi ................ 65
Go tswa ka soba la mogodu .................... 66

Treatment of diseases ................................ 66
Non-interference by witchcraft .................. 66
Promotion of physical and mental well-being 66
Promotion of family and social well-being ..... 66

Values and Norms Regarding Caring ........... 67
Caring Values ....................................... 67

Domain Number 3: Cultural Taboos and Myths 67
Beliefs and Values Relating to Taboos ........... 68
Neglect of cultural rites and ceremonies .......... 68
Neglect of social norms and values ............. 68
Care during high risk periods .................... 69

Domain Number 4: World View and Ethnocentric Tendencies 69
Views on Health .................................... 79
Views of illness .................................... 79
Views of care givers ............................... 69

Views on Those Who Receive Care ................ 70
CHAPTER 6 : THEORETICAL FRAMEWORK .............................................. 123

Introduction ................................................................. 123

Cooperation ................................................................. 123

Theoretical Models .......................................................... 125
The What — Why Model .................................................. 126
Anderson’s Nurse — Client Negotiation Model ....................... 126
Leininger’s Trans — Cultural Health Care Model ....................... 127

The Situation in Africa ...................................................... 128

The Cross-Cultural Collaborative Health Care (CCHC) Model .......... 129
Level 1: Preventive and Promotive Care ................................ 129
Level 2: Decision-Making .................................................. 129
Level 3: Collaboration/Negotiation ....................................... 129
Making the Model Operational ........................................... 131

Summary ................................................................. 132

CHAPTER 7 : SUMMARY, CONCLUSIONS and RECOMMENDATIONS ....... 133

Summary ................................................................. 133

Objectives ................................................................. 134
Objective 1 ................................................................. 134
Objective 2 ................................................................. 135
Objective 3 ................................................................. 135
Objective 4 ................................................................. 136
Objective 5 ................................................................. 136

Conclusions ................................................................. 136

Recommendations .......................................................... 137

References ................................................................. 140

Annexures ................................................................. 166

xii
Tables

Table 1: Health Care Personnel Staffing: Northwest Province, 1993 ......................... 10
Table 2: Regions of the Former Bophuthatswana Homeland ........................ 48
Table 3: Rural Clinics Selected by Regions ............................................... 48
Table 4: Leininger’s Culturologic Assessment Domain ................................... 59
Table 5: Domain Number 1: Patterns of Life-style of an Individual or Cultural Group .. 60
Table 6: Expressed Patterns of Life-style ................................................. 60
Table 7: Observed Patterns of Life-style ................................................. 62
Table 8: Observed or Stated Values Regarding Health Care .......................... 64
Table 9: Stated Norms, Values and Behaviour Regarding Caring .................... 67
Table 10: Beliefs and Values Relating to Taboos .................................... 68
Table 11: People’s World Views and Ethnocentric Tendencies ....................... 70
Table 12: Cultural Diversities, Similarities and Variations ........................... 71
Table 13: Domain Number 5: Categories, Themes and Responses ................. 71
Table 14: Diseases and Health Conditions Taken to Healers ......................... 72
Table 15: Life Caring Rituals and Rites of Passage ................................ 73
Table 16: Categories, Themes and Responses .......................................... 73
Table 17: Folk and Professional Health-illness Cultural Systems ................... 74
Table 18: Domain Number 7: Categories, Themes and Responses ................. 75
Table 19: Diagnosed and Treated Diseases of Children ............................... 76
Table 20: Diagnosed Gynaecological Diseases/problems ................................ 76
Table 21: Diagnosed Sexual Problems ..................................................... 76
Table 22: General Diseases Diagnosed and Treated by Healers ....................... 77
Table 23: Diagnosed Family Health Problems .......................................... 78
Table 24: Family Preventive Measures .................................................... 81
Table 25: Specific Caring Behaviours and Nursing Care Values, Beliefs and Practices ................................................. 83
Table 26: Domain Number 8: Categories and Themes .......................................................................................... 83
Table 27: Cultural Changes and Acculturation Aspects ............................................................................... 85
Table 28: Users' Views of Contributions of Indigenous Healers ................................................................. 85
Table 29: Users' Views of Diseases of Children Prevented by Indigenous Healers ............................................. 86
Table 30: Users' Views on Preventable Adult Diseases and Conditions ......................................................... 87
Table 31: Users' Views of Situations Against Which Family Preventive Measures are Taken .............................. 87
Table 32: Users' Views of Diseases Successfully Treated by Indigenous Healers ..................................................... 88
Figures

Figure 1: Map of Bophuthatswana Homeland ........................................ 4
Figure 2: Leininger's Theoretical/Conceptual Sunrise Model ....................... 13
Figure 3: The African View of Life After Death ..................................... 26
Figure 4: Bones Used for Divination .................................................. 89
Figure 5: Typical Setswana Divination Hut ........................................ 90
Figure 6: Interior of a Healer's Dispensary ......................................... 91
Figure 7: Equipment Used for Administration of an Enema ....................... 93
Figure 8: Patient With Breast Cancer ............................................... 95
Figure 9: Ancestral Veneration Ceremony .......................................... 96
Figure 10: Thwasa Initiate Dancing While in Trance ................................ 96
Figure 11: The Cross-Cultural Collaborative Health Care (CCHC) Model ...... 130
Figure 12: Portion of Rites Practised in Cleansing Ritual ....................... 201
Figure 13: Horn Used by Healer to Store Medicines .............................. 202
### Annexures

<table>
<thead>
<tr>
<th>Annexure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annexure 1</td>
<td>167</td>
</tr>
<tr>
<td>Indigenous Healers' Code of Ethics: The Healer's Oath</td>
<td></td>
</tr>
<tr>
<td>Annexure 2</td>
<td>169</td>
</tr>
<tr>
<td>Healers Council</td>
<td></td>
</tr>
<tr>
<td>Annexure 3</td>
<td>172</td>
</tr>
<tr>
<td>Request for Consent to Conduct Research</td>
<td></td>
</tr>
<tr>
<td>Annexure 4</td>
<td>174</td>
</tr>
<tr>
<td>Protocol for Co-Coder: Content Analysis of Data Obtained in Research Project</td>
<td></td>
</tr>
<tr>
<td>Annexure 5</td>
<td>177</td>
</tr>
<tr>
<td>Transcription of Interview No 7 to Demonstrate the Method of Content Analysis Through Underlining Words and Themes in Setswana and English</td>
<td></td>
</tr>
<tr>
<td>Transcription Version of Interview No 7</td>
<td></td>
</tr>
<tr>
<td>Annexure 6</td>
<td>197</td>
</tr>
<tr>
<td>Permission to Conduct Research</td>
<td></td>
</tr>
<tr>
<td>Annexure 7</td>
<td>199</td>
</tr>
<tr>
<td>Cleansing Ritual: A Case of Spirit Separation</td>
<td></td>
</tr>
<tr>
<td>Annexure 8</td>
<td>203</td>
</tr>
<tr>
<td>List of Medicinal Plants Found in the Gardens of Indigenous Healers and Their Usage</td>
<td></td>
</tr>
</tbody>
</table>
Definition of Terms

- **Appropriate health care**: health care that is basic, practical, affordable, available and accessible to the people in the areas in which they live. Appropriate health care is health care that is provided for the people and by the people themselves — this is relevant because it meets their daily health problems and needs.

- **Badimo**: ancestors.

- **Badimo ba re fularete/A baphansi basifulathele**: the ancestors have turned their backs on us.

- **Badimong**: an abode for the ancestors.

- **Baswing**: a temporary place where the dead reside before they go to Badimong.

- **Bongaka**: the power to become an indigenous healer.

- **Boraditaola**: bone throwers.

- **Boraditlamatlama**: herbalists.

- **Blacks**: black people of South Africa. In this study "blacks" refers to indigenous African-speaking ethnic groups.

- **Busa/Ukubuyisa**: to bring back and integrate the spirit of the dead to join those in the world of the ancestors (Tyrrel & Jurgens, 1983:53).

- **Culture**: the sum total of the lifestyles, social patterns, beliefs, attitudes and commonly accepted ways through which a community attempts to solve its life problems.

- **Disangoma**: diviners.

- **Disease/Illness**: any physical or psychological maladjustments, as well as the reaction of the client to a health problem, including disturbances in social relations (Kleinman and Sung, 1979:8; Bichman, 1979:177). In this study "disease" and "illness" are used interchangeably.

- **Ecologist**: a person concerned with the relation of people to their environment (Oxford Dictionary, 1978).


- **Go fisa**: heat (Krige, 1954:55).

- **Intlolome**: an impromptu drama among the Xhosa people in which each participant relives events and feelings from the past to the present. It is an indoor ritual the basic activities of which are singing and clapping of hands (Buhrmann, 1982:42).

- **Lefaseng la batshedle**: the world of the living.

- **Lenaka**: A horn in which mixed traditional medicines are stored.
Makgome: a severe illness related to having sexual intercourse with a bereaved woman during her period of bereavement (Magoba, 1984:36; Krige, 1954:54) or to the tracks of such a person (Monnig, 1967:67-68).

Malwetsi a modimo: diseases caused by God; natural diseases.

Malwetsi a batho: diseases caused by people


Mmopi/Motlhodi: the Creator.

Motho ke motho ka batho: the individual is a person because of his relationships with other people.

Psychotherapy: specific and specialized action taken for the purposes of positively influencing the human mind and behaviour for purposes of promoting mental health and well-being (Lambo, 1973:311).

Phogwana: a disease affecting children, usually under the age of three years, found among indigenous South African blacks and characterised by diarrhoea, vomiting and dehydration (Monnig, 1967:102).

O ile badimong: he or she has joined the ancestors.

Ontology: branch of metaphysics dealing with the nature of being (Oxford Dictionary, 1978).

Role: social, cultural, religious and psychological expectations of the people.

Senyama/Madimabe: an impurity that enshrouds one and which is regarded as a state which brings about misfortunes, sickness, loss of a job, unlovliness, or a rift between one and one's ancestral spirits. It underlies the purification rituals which are performed by the majority of black South Africans (Vilakazi, 1965:92).

Indigenous healers: indigenous African healers who divine and diagnose health problems through means other than western and whose medical practice includes the use of plants, animals and other materials as well as methods based on socio-cultural and religious values (Edwards, 1985:85).

In this study the term indigenous healer will be used and includes diSangoma, bone-throwers and herbalists.

Traditional medicine: indigenous African medical practices passed down from generation to generation and used for the diagnosis, prevention or cure of physical, mental or social health problems (Koumare in Bannerman et al, 1983:25).
Traditional Tswana Setting

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CHAPTER 1

Introduction

This starting point ... is largely a matter of identifying what it is that deeply interests you (Van Manen, 1990:40).

For many years health services in South Africa have neglected the contributions of Indigenous African healers to health care by legally disapproving of their services (van Rensburg, 1981:44). To most people whose culture is western, indigenous healers are considered deceitful and unscrupulous witch-doctors practising witchcraft (Mankazana, 1979:1003; Henning, 1992:40; Pitje, 1978:6). To the indigenous African however, indigenous healers are a source of health care. This study explores the contributions of Indigenous African healers in relation to the prevention of diseases and the promotion of public health among South African blacks.

This introductory chapter is intended as follows: it first outlines the historical background of health care practice and control in South Africa. It also gives background information about the Northwest Province and the structure of the health services in that region. An outline of the purpose of the study, its significance and basic assumptions are then provided. The research question that has directed the study and the methodology used is outlined, after which terms used in this study are defined. Finally, the organization of the research report is outlined.

Historical Background to the Study

Historically western medicine was only introduced in Africa in the 17th century by medical practitioners on expedition and by the missionaries (WHO, 1978). When their service was extended to the native population of South Africa, it found indigenous healers providing health care according to African culture (WHO, 1978).

Legal Control

The suppression of the practice of indigenous healing in South Africa is traced back to the beginning of the 20th century when the governor of Bloemfontein urged that the practice of "witchcraft" be stopped, and that legislation be promulgated for the prosecution of indigenous healers (Dennis, 1978:59).

The missionaries compounded the legal problem by teaching church converts that indigenous healing was evil and unchristian and should be done away with (Kruger, 1978:12). Missionary medical and nursing schools also brought this same message to the providers of health services. Consequently these teachings created a conflict between indigenous healers and practitioners of western medicine.
However, after many years of suppression of the activities of indigenous healers there remains enough evidence to indicate that the majority of black people in South Africa continue to consult with and use the services of indigenous healers (Bodibe, 1988:24; Mankazana, 1979:1004) Even though there are no official statistical records of those who have successfully utilized their services and benefitted from them. Research indicates, however, that 70% to 90% of diseases are managed exclusively outside the parameters of the formal health services (Kleinman et al, 1978:252). Eighty (80%) percent of Africans consult indigenous healers before seeking medical assistance from clinics or hospitals (Gumede, 1990:iii; Mutwa, 1974:79).

The continued existence and functioning of indigenous healers among black people is a result of the influence they have had throughout history, first on the kings and chiefs and then on the people. This occurred despite efforts of the government and missionaries to convert the people from “heathenism” in order to “civilize” them (Sillery, 1974:14). What has often been overlooked by those in authority is the benefit that could be derived from identifying, using and retaining components of indigenous healing, and articulating the two systems of health care through such retention (Etkin, 1979:397). The suppression of indigenous healing has been described as follows:

To deny that the human being has healing talents is to deny an aspect of reality simply because it does not fit in with our notion of mechanical physiology and anatomy (Kruger, 1978:12).

The failure of formal medicine to provide adequate health care

Since the Alma Ata Conference in 1978, primary health care has been propagated as the solution for the provision of accessible health care for all people. Primary health care is “essential health care based on practical, scientifically sound, and socially acceptable methods of technology made universally available to individuals and families in the community through their full participation, and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination” (WHO, 1978). MacDonald (1993) views community participation, equity and intersectoral collaboration as pillars of primary health care in bringing health care closer to the people. After the enthusiasm with which the concept of primary health care was received as the solution for achieving health for all however, it does not seem to have accomplished the objective. It has not been successfully implemented, even though governments felt committed to implement primary health care in their countries. While South Africa also strived to accomplish this, as yet it has not fully materialized. The current situation is that formal health services remain inaccessible to a large section of the population, especially those in the rural areas and in the townships’ shanty villages, despite the policy of free health services for certain at-risk population groups.

The problem is compounded by the fact that the term primary health care means different things to different people. To some it means primary medical care, and to others, rural health care, while others understand it to mean the training of health care workers and promotion of traditional birth attendants
(Maluleke, 1994:40). According to this author, the different meanings led to two types of approaches to the implementation of primary health care: the selective approach and the comprehensive approach. South Africa presently uses the selective approach which appears to be ineffective.

One of the primary reasons for the lack of success in implementing the primary health care approach in this country can be attributed to the existing conflicts between indigenous healers and those formal health practitioners who adopted the missionary ideas about African culture (Sillery, 1974).

Additionally, a misconception has been created in South Africa that health care in clinics or hospitals is the best — that health care provided by alternative sources such as indigenous and other types of healers is, at best, second class care or, at worst, witchcraft (Eboboyi, 1982:221). To blindly accept western-style medical care in South Africa, as well as and developing countries throughout the world, without considering the damage that such blind acceptance could cause, has proven to be a serious mistake. Ebomoyi (1982:221) argues that people have been seduced into believing that hospitals, doctors and advanced technology are the main answers to their medical problems. As a result, the efficiency of the indigenous health care of Africans has either been questioned, suppressed or ignored (Sillery, 1974:19). In South Africa negative attitudes toward those who needed health care the most stopped implementation of the findings of the Gluckman Commission in 1945 that all sections of South Africa must receive health services. With promulgation of the Health Act (Act 36 of 1977) however a shift in emphasis from curative to promotive and preventive health care began.

In the Northwest Province the issue is compounded by the fact that health care services are hospital-based. Primary health care cannot be fully provided when health services are institution-based. Secondly, nurses have been trained to provide care either in hospitals or in clinics. Home visits occur only as follow-up calls to patients discharged from hospitals. Community health practitioners need comprehensive orientation to primary health care approaches, but are only going through the process of selective orientation. As the result of shortages of qualified medical personnel, what was called “primary health care” was in fact, a physical health assessment for the screening of diseases. This is selective primary health care which is the extension of medical care (Maluleke, 1994:47). Primary health care is care that is readily available and accessible to the people who can also fully participate in its provision using socially acceptable methods and technology (WHO, 1978). Therefore, for health care to be termed “primary health care” the community must have full participation in it so that they are self-reliant rather than solely reliant on hospital or clinic personnel.

In terms of reference the Gluckman Commission was to report on: 1) the provision of an organized National Health Service in conformity with the modern conception of “health” which would ensure adequate medical, dental, nursing and hospital services for all sections of the people of the Union of South Africa; and 2) the administration, legislative and financial measures need to provide South Africa with a National Health Service.
Figure 1: Map of Bophuthatswana Homeland
Current South African health policy makes provision for free health services for pregnant mothers and children less than five years of age. While this approach to health care helps, it is a temporary measure in that it does not empower communities to develop themselves in preventing diseases and promoting health. No government can provide this type of service forever. What is needed is an approach that will, in addition to the immunization of children and health education, enable communities to:

- provide clean sources of water and basic sanitation facilities;
- offer pre- and post-natal care of mother and baby;
- prevent major communicable diseases; and
- provide appropriate treatment of local diseases for and by themselves (Ebrahim & Ranken, 1992:7).

In other words, primary health care enables people to provide care for themselves while the support of formal health services for training and referral are needed (Ebrahim & Ranken, 1992:7).

With the introduction of medical aid schemes, health care has become a commodity that is sold at high cost. It can therefore be argued that except for the free health services, health care has become either inaccessible, unavailable or not affordable to the poor; especially in the rural and peri-urban areas. Not belonging to a medical aid scheme, or coming from a financially disadvantaged position, prejudices a person’s access to health services (Benatar, 1989:559). This state of affairs seems to undermine the spirit of the Geneva Declaration recited by nurses during their pledge of service in relation to not allowing social and financial standing to stand between the nurses and their patients (the Nurses’ Pledge of Service). As a result, health services do not meet the basic health care needs of the majority of the people who need it most, and can therefore be considered inadequate (Kaya et al, 1991:3).

Buch states:

We have also failed to develop any successful national campaigns e.g. on the use of oral rehydration solution to prevent death from Diarrhoea — the biggest killer of children in the developing world (Buch, 1989:35).

The above statement seems to indicate how poorly available technology has been used to address health issues in South Africa. The problem is accentuated by the fact that the socio-economic origins and the fundamental causes of illness seem to be ignored by the majority of health personnel whose training programmes exclude basic indigenous health values and health practices of the indigenous black people (Kaya, et al: 1991:14).

Moving towards an inclusive health care policy

One of the priority objectives of the Reconstruction and Development Programme (RDP) in South Africa is to ensure that culture forms a basic part of development. Similarly, one of the programme objectives is to link culture firmly with health to ensure that health forms part of fundamental development. The indigenous healers’ cultural way of dealing with health problems is part of such development. In shifting
and restructuring resources, the African National Congress (ANC) places indigenous healers sixth on the
list of priorities (ANC, 1994). This is due to the fact that alongside the accepted formal health services,
traditional cultural beliefs and practices are still widely held among Africans who use both systems of health

Observation of patient records in the clinics and hospitals of the former Bophuthatswana show that there
are "defaulters" (those who fail to come back) among those attending health services in the region. From
this observation some questions automatically arise:

- Do the defaulters really default?
- Why do they default?
- If they "drop out" of the formal health service, where to they "drop into?"
- To what extent do the indigenous healers influence the defaulters or drop-outs?

Observation, as a community health worker, has shown that people do not start by going to the hospital
or clinic when a family member is ill. The family first makes a tentative diagnosis of what could be wrong
with the patient and tries possible solutions to the problem. It is, in many instances, not unusual that
indigenous healers are number-one points of contact in matters affecting health at the community level after
preventative and sometimes curative measures tried within the family have proven unsuccessful. This is due
to the involvement of indigenous healers as family practitioners; for in black families every family has its
own healer to protect the household and its occupants from a number of unwanted incidents (Gumede,
1990:101). It could be that beyond the family level there exists a whole range of indigenous healers from
generalists to specialists.

Statement of the Problem

The new National Health Plan for South Africa (ANC, 1994:55) and the Reconstruction and
Development Programme (ANC, 1994:29) does indeed make provision for the official utilization of
indigenous healers in the provision of health care in South Africa. However, before the level and nature of
this potential involvement of indigenous healers in the provision of formal national services, pertinent
questions are in need of investigation.

- Do indigenous African healers contribute to health care at all?
- If they do, in what way do they contribute towards the prevention of diseases and promotion of
  health?
- Which health problems are taken to indigenous healers?

The scope of this study is to investigate the above questions in order to respond to the research question
posed in this thesis: How do indigenous African healers contribute to health care among South African
blacks residing in the Northwest Province? It is hoped that the conclusions drawn here will enable the informing of national decision makers on this very important issue.

The Present Situation

The current situation is that the document on health priorities in the Reconstruction and Development Programme puts the indigenous healers sixth on its list of priorities (ANC, 1994). Although, at the very least, the contributions of indigenous healers are recognised, the National Health Plan does not indicate the levels of operation at which indigenous healers will function; nor is there any indication of the specific roles they will play.

Moreover, observation by the researcher during discussion in the meetings of the Health Forum for the Northwest Province during 1995 showed that the majority of medical practitioners continue to associate indigenous healers with practices of witchcraft. Medical practitioners do not accept indigenous healers as partners in health care. These negative attitudes of western-trained health workers, especially the medical practitioners, have historical roots and are persistent despite the reality that some people turn to the services of indigenous healers when there is failure to meet their needs by the formal health care sector (Foster, 1977:533).

Observations of patients in clinical areas by the researcher in the out-patient department of one referral hospital in the Northwest between 1977 and 1982 have also shown the use of indigenous healers by communities attending formal health services. Sometimes both formal health workers and indigenous healers are consulted. There are also indications that indigenous healers are effective in the management of certain health problems — especially those relating to mental health (Hogarty, 1971:201; Torrey, 1971:20; Coppo, 1983; Griffiths and Cheetham, 1982; Buhmann, 1981; Manganyi, 1974).

The Alma Ata Conference Declaration (WHO, 1978) states that the attainment of health is the most important social goal. The primary health care approach, as proposed by the Conference, advocates, among others, the following principles:

- equitable distribution of health care resources and adequate care for all;
- active community participation in health care matters;
- a sharp focus on preventative and promotive health care; and
- use of a multi-sectoral approach to health care.

In South Africa these principles have not, in any way, been implemented in the past, although some efforts are being made under the new dispensation. As outlined in the first section, the approach to primary health care in South Africa has been selective in that indigenous healers have been left out of the health care scene. Moreover, the implementation of these strategies has proved, in the South African context, to be most difficult (MacKenzie & Mazibuko, 1989:30). With evidence that 70% to 90% of populations in developing
countries are not covered by formal health services and resort to indigenous healers (Bichmann, 1979:176; Hennig, 1992:40), the need for mobilization of all health resources within South Africa becomes even more urgent.

The proposal to include indigenous healers in formal health service structures demands the need to specify those areas where they will be of greatest service. This will facilitate appropriate use of human resources in a country where health manpower is inadequate. If health care reforms are to affect change in meeting the basic health needs of the people of not only the Northwest Province but South Africa as a whole, the determination of the preventive, promotive, curative and rehabilitative activities of indigenous healers in the region is crucial to implementation of the desired reforms.

However, no exact information on indigenous healers is currently known in the Northwest region of South Africa. The nature of their health care activities is also unknown. The extent to which the users of formal health services consult with healers is also not known, as are the conditions for which indigenous healers are consulted. There is no evidence that those in opposition to the services of indigenous healers are that aware of the health services and activities of this group. Until these facts are investigated, indigenous healers may remain isolated from sectors of formal health services despite requirements of the National Health Plan. It will be difficult for South Africa, as in other countries (Asuni, 1979:33), to plan for any cooperation with indigenous healers without prior knowledge of the kinds of health problems they address.

According to De Beer (1976:433), the criteria for health services in South Africa are that these services should be accessible to a minimum of 80% of the total population, and be relevant to meet the specific needs of cultural groups within the constraints of the country’s available resources. Such a health service should maintain a balance between the preventive, promotive, curative and rehabilitative components of health care. The author further mentions that private practitioners should be allowed to operate without obstruction within such a service and that through networking, they should allow for expansion and effective communication, coordination and team work. Indigenous healers are private practitioners in their own right; and the above statement implies as much to formal health practitioners as it does to indigenous healers. This is in line with the principle of primary health care, and of fostering the spirit of self-reliance and self-determination as outlined by the World Health Organization (1978). Accordingly, health services should meet regional needs with clients being treated at grassroot levels (Freeman, 1992:30). With the exception of curative services the above-mentioned criteria, as they relate to the people in rural areas, have not been met (De Beer, 1976:433). Therefore, it remains the responsibility of the communities to deal with their own health problems in the manner they consider most effective. It is within this context that a critical look at the health activities of Indigenous African healers has been taken so as to determine the extent of their contribution to meeting the health needs of blacks in the Northwest Province.
The Northwest Region: Background Information

Description of the Province

The Northwest Province is made up of the former Bophuthatswana homeland as well as farms and towns which formed a part of South Africa before 27 April 1994. These areas include Marico, Zeerust, Koster, Rustenburg, Brits, Ventersdorp, Delareyville, Vryburg, Schweizer-Reineke, Bloemhoff, Wolmaranstad, Klerksdorp and Potchefstroom. Except for the white communities and towns, the province is basically rural with the former homeland forming 80% of the region. The province is situated between 24° and 30° latitude south and 22° to 29° longitude east within the interior of the Republic of South Africa. The former Bophuthatswana was made up of seven separate blocks of land arranged in jigsaw puzzle lying across the northwest portion of the South African plateau. It was divided into twelve regions and shared common borders with Botswana on the north (see Figure 1).

The first block of land made up the Kudumane (Tlhaping-Tlharo) and Ganyesa regions and was situated in the western part of the province. Southeast of the above region lies Taung. Molopo and Ditsobotla regions made up a block situated more to the central and northern portions of the province. Further north lay the fourth block formed by Lehurutshe and to the east the fifth block, made up of Madikwe, Mankwe, Bafokeng and Odi1. Near Pretoria in the east was situated the remainder of Odi 2 and Moretele. Two hundred and fifty kilometres southeast of the Taung Region, and completely separate from the rest of the country lay Thaba-Nchu near Bloemfontein in the Free State. This area encompassed 44,000 square kilometres (1,988.488 square miles) divided into 885 villages with a population of more than two million, 80% of which continue to live in the rural areas (Procter, 1989:582).

Structure of health services

The delivery of health services in the Northwest Province remains the responsibility of the provincial Department of Health — even during the period of reconstruction and development, health services continue to function according to the foundations laid by the former Bophuthatswana. Since 1975 the philosophy of providing primary health care services, with strong emphasis on bringing health as close as possible to where the people live, has been subscribed to. The plan has been to locate the clinics within a village catchment area of a five-kilometre walking distance — these services being merely an extension of the curative services offered at community hospitals since the centres exist only for treatment of diseases, not for delivery of primary health care.

Data gathered in 1992 and 1993 show, within the ambit of the WHO and given the statistics that follow, how impossible it would be for formal health workers to meet the primary health care needs of the majority of the province’s population.

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Chapter 1 — Introduction: p.9
Based on the 1985 Population Census of the former Bophuthatswana homeland and based on an Annual Growth Rate of 2.865, population projections for 1992 were 2,192,242 and are expected to increase to 2,679,086 by the year 2000 (Bophuthatswana Centre for Health Statistics, 1992:7).

More than three-quarters of the population living in rural areas do not have access to formal medical practitioners. The inability of formal health care practitioners to deliver adequate health care to three-quarters of the province's population is clearly indicated in Table 1 (Department of Health and Social Services, 1993).

**Table 1: Health Care Personnel Staffing : Northwest Province, 1993**

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>NUMBER of POSTS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Filled</td>
<td>Not Filled</td>
<td>Total</td>
</tr>
<tr>
<td>Medical Practitioners</td>
<td>127</td>
<td>128</td>
<td>255</td>
</tr>
<tr>
<td>Registered Nurses</td>
<td>4727</td>
<td>847</td>
<td>5574</td>
</tr>
</tbody>
</table>

Former Bophuthatswana Centre for Health Statistics, 1992:6

Of the 255 posts for medical practitioners, 127 (49.8%) were filled (Bophuthatswana Centre for Health Statistics, 1992:6). This constitutes a ratio of 1:17,262 — the availability of one medical practitioner per 17,262 members of the province's population. Bearing in mind that curative care is a component of preventive care, it would be impossible to provide adequate curative care with so few medical practitioners, even in provincial hospitals. Of the medical practitioners occupying posts, none had previously worked in rural areas. Most of them were expatriates who neither spoke the indigenous languages nor understood the culture of the people living in the Northwest Province. The few black medical practitioners coming from the ethnic groups within the former homeland were trained in urban environs and therefore not equipped to practice in rural areas. Consequently, more than three-quarters of the population living in the rural areas of the province currently continue to have no access to the services of western-trained medical practitioners.

In contrast to this, there were 5,574 existing posts for nursing practitioners. Of these 4,727 (84.8%) were occupied as of December 1994; and most of them were allocated to hospitals. The figures indicate that the health services provided for the rural population in the former Bophuthatswana are to a large extent dependent upon the availability of skilful community health nurses who, in fact, form the backbone of the entire provincial health service. Considering that the rural areas are sparsely populated, there are not enough nurses available to provide needed primary health care in the rural villages. This information also shows the lack of access to medical care since registered nurses in the clinics prescribe medicines within certain limits.
Some of the rural clinics are run by enrolled nurses who may not prescribe medicines due to their limited training.

Furthermore, the ideal of providing health facilities within a catchment area of 5 kilometre walking distances has not always succeeded since some of the clinics have not been able to function due to shortages in state funds. The available health services consisted of 18 health wards with a total of 233 state-owned, fixed clinics throughout the country. Of these 33 (14.6%) were not functioning as of December 1994, Kudumane and Ganyesa having the higher number of non-functioning clinics (17) (former Bophuthatswana Department of Health, 1992).

There were 220 mobile clinic points in the former homeland with Moretele 2 Region having one mobile point per month. To date there are no basic health services available to those people without access to mobile clinics. Therefore, for most rural people becoming ill means walking to the clinic, which may in any case not have all basic medicines in stock. It may also mean a costly bus ride to the local community hospital where the client is expected to queue and wait for his/her turn to be examined by an unknown nurse and/or medical practitioner. The patient may also be told to come back the following day either because complete consultation could not take place due to long queues, or because the drug dispensary was closed. Savage and Benatar (1990:152) and Buch (1989:34) have also made similar observations. This information proves the inadequacy of the formal health care system in terms of meeting the health needs of those requiring it most. In some areas health care, especially medical care, is inaccessible.

Buch (1989:34) states that while 12% of the health budget in South Africa is allocated to rural areas where the majority of the black population lives, only 4.7% of the total budget is allocated for preventive health care services in these areas. In the former Bophuthatswana no specific amount was allocated for primary health care services for 80% of the population, all of whom are rural dwellers. With the reconstruction and development of health services in the country, and with the shift from curative care to greater emphasis on primary health care and the equal distribution of resources to areas of greatest need, the picture seems to be changing.

The unequal distribution of financial and manpower resources has resulted in inadequate supplies of some of the basic resources necessary to provide care within the health services. The result has been the lowering of standards of care, particularly in the rural clinics (Bophuthatswana Nursing Association, 1992). The health coverage problem has become compounded by the growing numbers of squatter camps suddenly mushrooming around the peripheral areas of towns throughout the province. Indigenous healers however remain readily accessible, in large numbers, in all areas where formal health services are difficult to find. These factors make indigenous healers the next logical health practitioners to consult.
Purpose of Study

The purpose of this study is to determine the role played by Indigenous African healers in the prevention of diseases and the promotion of health; and to formulate guidelines for cooperation between indigenous healers and formal health care workers. This has been accomplished with achievement of the following objectives:

- exploring roles played by Indigenous African healers in the prevention of diseases and the promotion of health at primary, secondary and tertiary levels;
- determining which health problems are taken to indigenous healers and identifying which diseases they prevent and which ones they treat;
- determining the levels at which cooperation between indigenous healers and formal health care workers could take place; and
- finding a cooperative model that could be utilized by both formal health care workers and indigenous healers in the provision of health services in the Northwest Province.

Significance of the Study

This study addresses an issue which has received scant attention in the health care delivery system in South Africa in general, and none in the northwest region in particular. The study is, therefore, of great significance to the Department of Health and Developmental Social Welfare in the Northwest Province since these findings will establish a knowledge-base through which indigenous healers could be utilized to the fullest. The study also hopes to assist in identifying the areas of preventive and promotive health in which indigenous healers are believed to be proficient so that relevant health problems can be referred to them for attention.

Research Model

Based on the findings, a cooperative model of operation between formal health workers and indigenous healers has been developed; and for the following reasons, Leininger's Trans-cultural Care Health Model (1980:210) forms the point of departure for the carrying-out of this study (see Figure 2):

- Firstly, nursing activities are at the heart of nursing practice. It is during nursing practice that cross-cultural health problems can be identified. It is also during nursing practice that research findings can be validated. In this study it was during nursing practice that the researcher became aware of indigenous health practices among the people of the Northwest Province.
- Secondly, nursing practice is concerned with research and the generation of theories in order to develop nursing knowledge. By exploring the role played by indigenous healers in the prevention of diseases and the promotion of health, it is hoped that the findings will contribute to further knowledge for improving the provision of community care throughout South Africa.
Leininger’s Theoretical/Conceptual Sunrise Model to Depict Dimensions of Cultural Care Diversity and Universality

Figure 2: Leininger’s Theoretical/Conceptual Sunrise Model to Depict Dimensions of Cultural Care Diversity and Universality

- Culture Care World View
- Cultural & Social Structural Dimensions
  - Kinship & Cultural Values & Social Factors Lifeways
  - Political & Legal Factors
- Influence Care Patterns and Expressions
- Health (Well being)

of Individuals, Families, Groups and Institutions

Diverse Health Systems

Folk System

Nursing

Professional System

Nursing Care Decisions & Actions
- Cultural Care Preservation/Maintenance
- Cultural Care Accommodation/Negotiation
- Cultural Care Repatterning/Restructuring

Culture Congruent Care

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 1 — Introduction: p.13
• Thirdly are the paradigmatic aspects to which the nurse declares the assumption he/she adheres, *ie* the meta-theoretical, theoretical and methodological as discussed in the following section (Modungwa, 1995:4).

**Paradigmatic view**

In the carrying out of this study the researcher views the research phenomenon as complex. The researcher believes that the holistic approach is particularly suitable for the study of phenomena such as peoples' cultural experiences. It is further believed that both the researcher and the respondents are equal partners in this study. As such, the Trans-cultural Care Model will be utilized (Leininger, 1980:210).

**Meta-theoretical assumptions**

According to the "Whole Person Theory" (Oral Roberts University Nursing Department, 1990:136-142) the following are taken for granted and, as used in this study, clarified in this section.

- **Person:** refers to indigenous healers, the health service users and the researcher. They are all spiritual human beings functioning within psychological and cultural dimensions in search of health care.

- **Health:** a state of physical, spiritual and mental well-being. The patterns of interaction between persons with their environments (both internal and external) may determine and influence their health status. Since in this study it is accepted that indigenous healers are external environmental factors in the lives of health service users, patterns of interaction between healers and users of health services could determine the person’s health status.

- **Community health care:** Community health care is an integral part of nursing. It is an interactive process between the community, health care providers and the patients, and is concerned with the prevention of diseases and the promotion of health at primary, secondary and tertiary levels.
  - *Health maintenance* refers to care activities that are directed at promoting and maintaining the health status of the person.
  - *Health promotion* refers to care activities that contribute to a greater degree of wellness in the person.
  - *Rehabilitation* refers to care activities that facilitate the restoration of previous levels of health, or a return to maximal functional ability.

- **Environment:** refers to the internal and external environments of healers and formal health care service users, and is multi-dimensional in scope. It includes physical, social, psychological, spiritual, religious and cultural dimensions.
Theoretical perspectives

Leininger’s Trans-cultural Care Model (1980:210) formed the basic guide for conducting this study. The model will however not be discussed until after data collection has been completed to show the results of the study.

The findings should further contribute to the planning of health care in terms of coverage, equity and mobilization of all available health manpower resources in the Northwest Province so that health care activities become community-based participatory efforts in accordance with the elements of primary health care.

The model developed in this study could assist indigenous healers and formal health care workers in utilizing culture-congruent and culture-specific health care approaches that would be more beneficial to users of both health services.

Research Question

Since this is a descriptive and not an experimental study, it has been thought unnecessary to formulate a hypothesis. Polit and Hungler (1983:134) state that:

... most research that can be classified as descriptive proceeds without a hypothesis.

The authors also state that qualitative research approaches are less suitable for testing a research hypothesis (Polit and Hungler, 1989:313). Dempsey and Dempsey agree with this view by stating that a hypothesis is optional in a descriptive study in which the investigator describes what is ... (1981:134).

The research question formulated asked: How do indigenous African healers contribute to health care among South African blacks residing in the Northwest Province? Existing literature shows that there is limited information available to answer this question. It also shows that no research has been carried out on the contributions of this type of health care workers in the Northwest Province. It is for this reason that the researcher investigated the premise outlined in the question.

Basic Assumptions

In this study it was assumed that:

- Indigenous African healers are health workers involved in the prevention of diseases and promotion of health at primary, secondary and tertiary levels.
- There are health problems peculiar to indigenous blacks that only indigenous healers are able to treat. Such health problems will only be taken to indigenous healers for treatment and care.
- There is an already-established informal system of utilization of both the formal and traditional health services by communities in both the rural and urban areas of the Northwest Province.
The decision to consult an indigenous healer is dependent upon a multiplicity of cultural factors related to the perception of health by an individual or a family group.

Indigenous healers undergo basic training which is different from that of formal health care workers, and may therefore be willing to learn some of the care activities performed by formal health care workers.

Indigenous healers are willing to be recognised as an integral component of the health care system in the new South Africa, and are willing to cooperate with formal health care practitioners and workers.

Research Methodology

Research Design

This is an ethno-medical, contextual and exploratory qualitative study. It is ethno-medical in that it investigates the health care of a specific ethnic group. It is contextual in that individuals in a specific cultural group served as samples for the collection of data. It is exploratory since it is meant to increase insight and generate meaning regarding the cultural preventive and promotive aspects sensitive to black peoples’ cultural health-illness needs (Burns & Grove, 1993:768). It is qualitative since it strives for the best possible understanding of the behaviour of illnesses and health care experiences based on cultural beliefs, values and practices (Polit & Hungler, 1989:312). It is concerned with gaining insight into the nature of experiences within health phenomena themselves rather than the numbers of people involved in the various experiences.

Study Population

The target population group for this study was adult African users of formal health care services and indigenous African healers above the age of 21 years who were Tswana-speaking since interviews were conducted in this Setswana.

Sampling Procedures

Sampling was conducted as follows:

- **Sample one**: From the twelve regions of the former Bophuthatswana five were selected. Simple random sampling was conducted in the Kudumane, Ganyesa, Molopo, Odi and Bafokeng areas; and purposive sampling was used with ten indigenous healers selected from these same five regions.

- **Sample two**: A second sampling of twelve people attending formal health care services in clinics was selected using systematic sampling. Every fifth person was selected.
Data Collection

Data was collected using in-depth individual interviews. The interview pattern was of an unstructured, free-attitude type with strict adherence to the research question. According to Marshall and Rossman (1989:82) this technique can vary depending on the degree to which the interview is structured beforehand and on the amount of latitude the interviewee is granted in responding to the question. A tape recorder was used to record responses during interviews; the information was then transcribed and coded. A camera was used to capture live experiences. Field notes were taken during all interview sessions. Observations made during each session were recorded.

Data Analysis

Data were analysed by means of content analysis through open coding, axial coding and selective coding. Tape-recorded interviews were transcribed word-for-word and coded. Data were grouped into themes and analysed. Inductive and deductive reasoning was used during data analysis.

Validation of Data

A triangulation was used whereby two coders were used to audit available raw data. Member checks were employed wherein the researcher returned to the healers to determine whether the transcribed information was correct.

Delimitation of the Study

The study was delimited as follows: Subjects were black people living in the former Bophuthatswana homeland. Only Indigenous African healers were observed and interviewed; users of both formal and informal health services were interviewed while out-patients at formal health care clinics. Since faith healers fall within the parameters of the church, they were excluded from this study.

Structure of Thesis

Chapter 1 serves as a general introduction to the study. It highlights some of the issues of concern about the services of indigenous healers and primary health care and explains the reasons for some of the perceived failures of the primary health care approach. It states the problem researched as well as the purpose, objectives and significance of this study. Finally, the chapter delineates the research methodology used in the study and outlines the structure of the .

Chapter 2 extensively reviews and discusses the literature relating to indigenous healers and their work in the provision of health care. In this chapter the African world-view of religion, health and life after death
are discussed. Beliefs about causes of illnesses and the role of indigenous healers in health care are also discussed.

Chapter 3 presents research methodology. Sampling procedures and ethical considerations for the study are discussed. Methods of data collection, data analysis and the limitations of the study are presented. Finally, the qualifications, descriptions of results and validations of data are presented.

Chapter 4 presents the analysis of collected data. Information collected from indigenous healers, field observations and from users of formal health care services is analysed and presented while Chapter 5 presents discussion of the analysed data.

Chapter 6 discusses the conceptual framework. It deals with the Trans-cultural Model of providing health care to individuals of different ethnic groups. A model of providing culture-congruent health care is provided. It outlines the manner through which the model could assist community health workers in the provision of a health service that is acceptable to those most apt to use it.

Chapter 7 summarises the study. In this chapter conclusions are drawn and recommendations are made.

Summary

In this section a historical background to the study and information about the Northwest Province is discussed. The problem under study is stated, as well as the purpose and the significance of the study. The research question is asked and some basic assumptions are made. A brief overview of the research methodology is presented and the manner in which the research report will be organized is indicated.
CHAPTER 2  

Literature Review

Those who do research belong to a community of scholars, each of whom has journeyed into the unknown to bring back a fact, a truth, a point of light. What they have recorded of their journey and their findings will make it easier for you to explore the unknown: to help you to discover a fact, to bring back a point of light (Leedy, 1989:66).

Introduction

The provision of services by indigenous healers is an important issue currently facing health-planners in South Africa, especially in view of the socio-economic and political constraints within which public health services are currently provided. However, an attempt to deal with the health problems of the black people of South Africa without an understanding of their culture would be fruitless. Health, illness behaviour and health care are all integrated into a complex network of beliefs and values that are part and parcel of culture (Bonsi, 1982: 1). To a large extent the philosophical, religious and cultural beliefs which form the fabric of African life impact on the views of Africans about health and illness.

In this section extensive literature review on indigenous healers is provided. A clarification of African cultural values and beliefs in relation to health and health behaviour is included.

An understanding of the concepts used in relation to the causes and classification of disease, as well as the hierarchy of forces to which everybody within the society is believed to belong, whether such a person is alive or dead (Bichmann, 1979:177), are discussed. In addition, the reasons for the utilization of the services of indigenous healers are presented to provide insight into the rationale for such use.

Utilization of Indigenous Healers

With the exception of mental health services (Green, 1980:489) there is no indication that people seem to question the role that indigenous African healers play in health care. With specific reference to the black people, the role of indigenous healers in health care should be viewed against the health and socio-economic backgrounds of the current South African situation.

Several reasons have been given for the simultaneous use of the services of western-trained health practitioners and indigenous healers by blacks (Fako, 1979). With the majority of the people living in rural areas where hospitals and clinics are scarce and located far away from the people, and with poor transport facilities which make health facilities virtually inaccessible to the people they are meant to serve, the indigenous healers are vital in meeting the health needs of the people (Dheyongera, 1994: 15). Gish states:

Even the rural health centre has become in many countries relatively too ... expensive and curatively oriented to be the primary unit for the direct provision of appropriate curative and preventive care (Gish, 1990:403).
People perceive disease as a cultural experience and interpret illness from a cultural perspective. Disease is responded to through behaviours and attitudes learned within one’s culture. The system of customs and beliefs, the social situations in which the client finds him/herself, and the stresses and strains to which the individual is subjected within the society determines whether or not indigenous healers should be consulted (Chavunduka, 1972; Fako, 1979).

Consequently people go to the hospital, clinic or pharmacy for drugs to address the symptoms of the illness but later consult indigenous healers to discover the actual cause of the illness as well as to obtain a meaningful explanation for their health problem (Fako, 1979:113). Additionally, people have their own health priorities and their own understanding of the problem is central to their health since they are likely to act on what they understand. The Director General of the Christian Medical Commission states, “We must have faith in the ability of the people, however uneducated they may be, to do things for themselves” (Ram, 1986:1).

There are indications that some black people use indigenous healers because the modern health sector has failed to express empathy in its contact with patients, has failed to demonstrate cultural sensitivity, and often fails to offer any psychological support to those who need it the most (Staugard, 1989:122). In fact this author holds that it is general frustration, rather than conceptual integration, which forces people in need of sensitive understanding of their problems to seek out indigenous healers. A study of patient compliance with doctors’ advice showed that patient-doctor relationships are the primary factor for determining whether or not the patient will comply with the physician’s advice (Davis, 1968:284). In this study, 37% of all respondents disregarded the doctors’ advice due to lack of good rapport on the part of the attending physicians. It seems crucial that the people be encouraged to be self-reliant through the retention, or the regaining, of control over decisions which affect their health. These are goals which should permeate all stages of socio-development, including primary health care (Ram, 1986:6).

Belief in the social causes of certain illnesses is an important determinant of a person’s decision to consult the indigenous healer in addition to, or as a substitute for, formal health practitioners (Ulin & Segal, 1980:61). The identification of a natural cause is therefore not a final determinant of the type of health service to turn to. In a study among the Shona of Zimbabwe for instance Chavunduka (1972:103) found that illnesses that were regarded as “normal” by the patient or his family were referred to the western medical practitioner and those that were regarded as “abnormal” (eg those related to witchcraft or the ancestors) were referred to the indigenous healer. This was due to the view that western-trained practitioners were unable to tackle the cause of the health problem (Chavunduka, 1973:27). Therefore, when what is regarded as natural illness becomes protracted and the patient’s condition deteriorates, attitudes change and a supernatural cause is sought (De Villiers, 1985:47).
The preceding information seems to indicate that some behaviours occur due to the need to find the causes to an existing health problem. Sarpong states:

The plain truth is that man has never found the answer to the question "Why?". All our scientific explanations answer the question "How?" (Sarpong, 1985:9)

This is an indication that culture determines health and the behaviour of illnesses (Gialli, 1973:9). In this regard, Brownell and his colleagues explain that a multidimensional approach to diagnosis and treatment is embedded in the profound knowledge of the cultural world. They further argue that a total acceptance of the world-view of the patient as well as complete faith in the potency of the treatment prescribed, are characteristic of indigenous healing practices in clarifying not only the “how” as in western approaches but also the “why” and “why me” questions (Brownell et al, 1987:38).

There is strong argument that formal health services do not reach many rural and peri-urban areas of Africa (DeJong, 1991:2). The problem is compounded by the high rate of population growth in South Africa which makes it difficult to maintain existing levels of health care coverage. One of the factors encouraging the utilization of indigenous healers is that they are readily available. This fact makes it convenient for the client to get health care at any time (Green, 1980:449).

The possibility that the continued use of healers could be as a result of dissatisfaction with formal health care services cannot be overlooked. According to DeJong (1991:7) dissatisfaction with modern health care results from its unsympathetic and unresponsive nature to the needs of African patients. The author further argues that formal health care is inaccessible in terms of costs and thus encourages the use of indigenous healers among Africans. According to the author, the choices to visit a healer often represents highly rational responses to the constraints and opportunities the people are face with (DeJong, 1991:7). Ademuwagun (1974:60) regards the questions asked by formal health care workers during consultation sessions as irrelevant, embarrassing, unsympathetic and culturally unacceptable questions that would never be asked by an indigenous healer. As such, selection of the alternative source of care enables patients to obtain acceptable and effective therapies at affordable costs.

A study conducted by Hammond (1982:40) among white people in Durban revealed that 62% of the sample used healers alternative to western medical services although initially they had actually been medically treated within the formal health sector. Of those in hospital 78% indicated that they would consult a healer and more than 50% of the patients had used healing methods other than those of the formal health services. It is apparent that the provision of health care is not an activity that is restricted to a single group of professionals, but is a multi-sectoral effort to achieve health care as a basic right for all people.

Another researcher in Iraq showed that the mere proliferation of health services does not necessarily meet the needs of the peoples’ health problems. Sugathan, et al (1982:218) found that even when a health care centre was available in the same village 46% of the people used it as an institution of first contact for
the total incidents of known illnesses. When the second episode occurred the centre was used only 3.5% of the time. In 40% of the known cases help was sought from elsewhere.

Statistics show that 70 to 90% of the total population in rural Africa is not covered by public health Services (DeJong, 1991:2). Two-thirds of the world’s people today depend on indigenous healing methods — especially those in the rural areas where health facilities are lacking (Edwards, 1986:1273; Nemec, 1980:5). A study in Nigeria showed that 92.3% of the respondents used the services of indigenous healers for excessive worries and 73% used them for sleeplessness (Ademuwagun, 1974:60). In the same study more than a quarter (26.8%) consulted faith healers and 19% consulted indigenous healers for antenatal care. Similarly, 22.3% consulted indigenous healers for post-natal care (Ademuwagun, 1974:67). With the increase in the growth of populations in the developing countries, coupled with the inability of these countries to maintain existing levels of health coverage, the people resort to indigenous healers to meet their health needs (Bichmann, 1979:176). That indigenous African healers are patronized seems unquestionable; and whether or not they administer herbs or psychotherapy, their services are used (Comaroff, 1978:251; Conco, 1991:9; Gumede, 1990:iii).

While it is acknowledged that preventable diseases continue to occur, the situation has not been matched by an increase in the allocation of financial resources for provision of primary health care. What also makes the provision of primary health care difficult is the failure to recognise the roles played by the indigenous healers in preventive health care among the indigenous people of Africa — especially in view of the fact that most psychological conditions are not, as yet, preventable through the use of western means (Bloom, 1979:189).

Indigenous healers continue to provide health services as well as a stable cultural and psychological support base in health care to the majority of the people; and sometimes they are the only source of health care available (Maclean & Bannerman, 1982:1815). In fact many indigenous blacks in South Africa utilize the services of western medical practitioners while others sometimes consult indigenous healers. Sometimes the same illness is referred at different stages and sometimes simultaneously to the two types of health practitioners (Bell, 1994:234; Christie, 1991:549; Feierman, 1981:399; Pearson, 1983:67; Senturias, 1990:5; Staugard, 1985:118). Even when the patient is hospitalized his relatives bring traditional medicines for use while in the hospital (Asuni, 1979:36). This behaviour is attributed to accessibility and the ability to meet the fees charged for the services of indigenous healers, as well as the fact that, for the majority of patients, indigenous healers are a part of the socio-cultural way of life (Kaya et al, 1991:4).

In other African countries indigenous healers are not only available where western-trained practitioners are not, but are available near or within the hospital grounds (Zeller, 1974:94). It has been argued that in spite of the great respect with which formal health services are held, it is rare in many African societies to find an individual who relies entirely on western medicine, especially in times of serious illness (Gumede,
This is attributed to the idea that certain health problems which formal health practitioners, trained according to western models, are unable to address (Mutwa, 1974:79; Chavunduka, 1972:8).

Health is a socio-political issue which cannot be judged solely by indicators such as disease prevalence and mortality rates. Such aspects as resources which enable the people to function and become productive, a sense of responsibility and involvement, self-sufficiency in all matters, and reliance only on outsiders for emergencies are some of the important health indicators (Newell, 1975:192) necessary for the success of primary health care is due to links between primary health care programmes with indigenous healers forming part of the programmes.

Indigenous African Religious Views

The concept of an “African world view” is an illusive one, difficult to define, but a product of metaphysics, African epistemology and axiology, and even African ontology and eschatology (Bodibe, 1990). An understanding of the role played by African indigenous healers in health care among Africans is dependent upon a clear understanding of the African world view. While it is correct to state that action cannot really be understood unless the belief and theory on which it is based is understood (du Toit, 1971:51), in this instance the converse is also true and applicable: belief cannot be fully comprehended unless it is seen in action. This brings into the open dynamics of powers and supernatural agents which cannot be learned from an objective statement of world views. It is through the understanding of the world view held by the people that one can better understand their beliefs and the values which underlie social interaction in African homes and communities. Thus it is that the African world view has great influence on the conceptualisation of health and illness among indigenous people, and is presented here.

African Religion

Religion forms an integral part of the African way of life. The fact that there are no monuments to portray African religion is an indication that Africans do not worship inanimate objects (Conco, 1991:2).

As part of everyday life, religion focuses on an invisible Supreme Being addressed in different ways by the various ethnic groups. With the exception of Hindu beliefs involving the worship of multiple gods it would seem that most people, including Africans, are monotheistic, believing in the existence of one Supreme Being (Conco, 1991:2), irrespective of how such a being is addressed. This view is contrary to the view that Africans were pagans before the arrival of the missionaries (Khumalo, 1988:7).

Modimo — The supernatural being

In African religion the concept of Modimo is derived from the original African stem dzimu which means spirit or pertaining to the spirit (Setiloane, 1986:24). For the African, therefore, Modimo has nothing to do
with heaven or above, but has everything to do with the spirit(s) in the world of the spirits (Badimong). A hierarchical chain of deities exists at the top of which is Modimo, ie Umvelingangi, Unkulunkulu, Tixo, Tilo, Mudzimu, the Great Spirit and Creator (Bownell et al, 1987:36; Green, 1980:491; Morse et al, 1991:1361; Tyrel & Jurgens, 1983:51-52; Schapera, 197:59; West, 1976:44). This Being is regarded as the most high, master of the universe and maker of the earth and all that is in the world. It is believed to be too remote to be involved in the daily problems of mankind and cannot be reached or directly approached. It is thought to wield most power in the spirit world and is never invoked (Vilakazi, 1965:89). No rituals are directed at Modimo (Farrand, 1980:89; Devilliers, 1985:398). African indigenous healing is intricately connected to the religious belief that indigenous people are connected to the chain of deities through a specific system of communication.

**Badimo**

Second to Modimo is Badimo, ie Amadiozi, Abaphanzi, Izinyanya, the people of the underworld, the ancestral spirits (Conco, 1991:12; Gumede, 1990:47; Tyrel & Jurgens, 1983:57). They are regarded as elders who have died rather than as gods. They are not worshipped but spoken to (bua le Badimo), and are delegated by Modimo to serve as intermediaries between himself and the people (Devilliers, 1985:399; Farrand, 1980:89).

Great importance is attached to the spiritual body and interpersonal components of life. The relationship with the ancestors, and through the ancestors with the people, permeates all life (Holdstock, 1981:128). The direct relationship between Modimo and Badimo is explained in the statement that in African custom, if a child does wrong and a ceremonial cleansing fails to bring about change, then the child is taken to the graveyard to speak to the people who are in the presence of God and Badimo, and ask them to intercede on our behalf (Hodgeson, 1983:13).

**Indigenous healers**

The healer is the functionary closest to the ancestors (Edwards, 1987:45) and is significant in determining the causes of illness and misfortune (Mabetoa, 1992:5). He/She is the key person in establishing contact and in communicating with the ancestors on behalf of the descendants. Communication takes place through techniques such as divination, possession states, dreams and veneration (Green, 1980:491; Junod, 1962, Vol.2:384; Mfusi & Edwards, 1985:16; Tyrel & Jurgens, 1983:58). In every case the healers satisfy a need of the members of the community by performing functions without which discomfort would result (du Toit, 1971:52).

The daily activities are delegated by Modimo to the ancestral spirits of each family who are directly subject to Modimo and are responsible to Him for the behaviour of their descendants (Broster & Bourn,
Africans believe that as much as the ancestors can bless they can also punish (Junod, 1962, Vol.2:386), hence the saying between the indigenous Sotho and Zulu people, *Badimo ba re fularetses* or *Abaphansi Basifulathele* (Edwards, 1985:26).

**The African World View of Life After Death**

Belief in continued life after death forms the basis of religion among Africans (Monnig, 1967:54; Conco, 1991:12) and should not be misconstrued as solely of Christian origin. The Christian theological doctrine is illogical and self-contradictory in its doctrine of “life after death” since it clearly denies any point of contact between the living and the dead (Setiloane, 1986:17). Contrary to western belief that after death one goes to either heaven or hell, Africans believe that there is life after death (Karlson & Moloatoa, 1984:26) and beliefs about world views cannot be disproved from the Bible or from physical science (McGregor, 1979:65). The Christian Bible makes mention of the existence of spirits and does not deny the presence of ancestral spirits (1 Samuel, 28:1). The belief that the living and the dead can communicate (Conco, 1991:2) and influence one another, and the influence that the living have on the ancestral spirits due to this communication, forms the basis of all rites connected with the ancestral spirits (Monnig, 1967:54). The ancestors therefore have to be thanked for their blessings. On the other hand, the ancestral spirits have unlimited powers over life and death, over sickness and health, and over poverty and prosperity. These powers are sometimes exercised over their living descendants so that the ancestors are always remembered (Monnig, 1967:54).

For an African life begins in the world of the spirits — *Modimo le Badimo*. It continues on earth and ends in the world of the spirits — *o ile Badimong* (Sarpong, 1985:10). Immediately following death however the spirit is believed to wander around in search of a place of abode in *Baswing*. After a funeral, a ceremony is performed to bring back (*go busa/ukubuyisa*) and to integrate the spirit of *Moswi* (the deceased) and usher it to join those in *Badimong* (the world of the spirits) so that it ceases to wander around (Tyrrel & Jurgens, 1983:53). Unborn children are believed to exist in the world of the unborn (Conco, 1991:13) and are looked after by the healers through indigenous medical care to ensure their good health even before they are born into the world of the living (Figure 2: The African Theory of Life After Death).

Generations on earth are supported by the generations of ancestors who are also considered alive and who use their knowledge of life and force to strengthen the lives of those on earth (Brownell et al, 1987:36). Clearly then the responsibility of *Badimo* is to take charge of their living descendants. For instance, Shona people believe that when a married person with children dies, his/her *mudzimo* (family spirit) continues to exert considerable influence, as well as a protective function, on the offspring. Should one of these spirits be annoyed over the transgression of a religious rite, ill health or even death may ensue (personal communication with Hlomai “Nyathi” Mabutho of Mashabe, Zimbabwe). The African view therefore does
Figure 3: The African Theory of Life After Death®

MODIMO
Divinity

BADIMONG
Life Everlasting
(World of Ancestors)
Healers communicate with the ancestors
spirits in this area.

LEPATHE LA BA BA MO MNELENG
The World of the Unborn
(Where the children are looked after).

BASWING
World of the Dead
(“Chukuyise”
ceremony is performed
for them here).

Lines of communication between Modimo and the Ancestors. Please note that Modimo does not have direct communication with anyone other than the Ancestors.

Lines of communication between the Ancestors and Indigenous Healers with ancestral spirits. Single arrow indicates one-way communication with Baswing.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Chapter 2 — Literature Review: p.26
not separate the human being into the compartments of body and soul. Instead, it views a human being as a vital force in continual and close relationship with the other forces around him (Schweitzer, 1985).

African Beliefs About Causes of Illness

A premise exists that illness-experiences are socio-cultural constructions developed by a patient and his social network within a specific context (Ness, 1980:176). Consequently, the effectiveness of treatment and care by indigenous healers involves the reconstruction of the meaning of the patient’s health problem. The patient defines himself healed if the healer’s diagnosis and treatment are congruent with his perception of the problem and treatment expectations. Since there is a belief that the underlying cause and not the pathological process is the major factor in illness (Foster, 1976:774) classifications of beliefs about the causes of ill health within the African world view should be understood. The understanding of the role of indigenous healers does not only rest on pathological concepts and disease classification, but also on the hierarchy of forces which are thought to belong to every being (Bichman, 1979:177).

Within the African context illness is viewed as an interpersonal imbalance as well as a cultural reaction to life. For an African to understand his/her health problem, reference should be made to his own understanding of relationships among the different interdependent life forces, such as the ancestors. The African social structure, with strongly-held health beliefs and convictions as well as patterns of behaviour, maintains the individual in social balance. Central to such social integration is the strict adherence to ancestral beliefs and veneration, ceremonies, rituals and observation of taboos, all of which sustain social cohesion (Chavunduka, 1978:19; Cheetham & Griffiths, 1982:954). Contrary to functions in modern culture the authors view African indigenous medicine as a focal point around which all life events, illness, disaster, subsistence and economy devolve (Cheetham & Griffiths, 1982:954). This holistic approach, free of differentiation between the physical and psychological origins of illness (Twumasi, 1972:56) has led to insight and success in treating illnesses that have psychosomatic components (Lambo, 1973:1321; Good, 1977; Harding, 1977:439; Foster, 1977:533). It is within this context that the role of the indigenous healer is considered paramount for it is they, in their capacity as diviners and mediators, who in the final analysis act as arbiters in matters related to health and sickness.

The conception of disease among western-trained health practitioners is different from that held by Africans. The approach to illness used by indigenous healers incorporates the world view of the culture within which traditional medicine is practised and the procedures followed are consonant with prevailing community beliefs (Cheetham & Griffiths, 1982:954). What appears mystical and magical to western thinking is actually quite the opposite for a black. To the latter magic is indistinguishable from medicine. According to Stayt the importance of the magical element is founded upon the concept that “every object, animate or inanimate, has an inherent kinetic power of good ...” (Stayt in du Toit, 1980:32). It means that
herbal and medicinal treatments do not depend upon magic for their efficacy. The question of supernatural forces as a therapeutic measure is also not new. Frank states:

The view that illness can be caused and cured by the intervention of supernatural forces stretches back to the furthest antiquity and continues to be important ... in most modern cultures (Frank, 1973:48).

This is because supernatural theory serves to reinforce the physical and mental well being (Twumasi, 1972:57).

This view is not only confined to Africans. An example is that of a highly respectable Negro physician whose foot pain was cured by a voodoo practitioner (Frank, 1973:49). Also there is among the Batswana molemo which refers to medicine and the generalized potency of drugs that heal: setlhare, which in the medicinal context implies a herb which could harm, and bongaka, which is the power of being an indigenous medical practitioner. Magic, as distinct from medicine, does not exist and the indigenous healer is not a magician but a ngaka using melemo to practice bongaka (Dennis, 1978:55).

Classification of causes of illness

Health beliefs are an integral part of the religious belief system and the causes of health problems or illnesses are central to the belief system of Africans. Among South Africans all requests relating to health and well-being are directed at the ancestral spirits (Vilakazi, 1965:89); and where there is illness the diviner finds the cause in other areas of life or in the spirits (Etkin, Ross & Muazzamu, 1990:921). African indigenous healers follow a basic philosophical pattern. First is the belief that disease is caused by an ancestral spirit which enters the body and causes ill health due to a break in relationship with their descendants either because taboos or certain rituals have been neglected, or due to the failure to perform a ritual. Illness could also be explained as being personal in nature caused by active, purposeful interventions by an agent who may be human, such as a witch. It can also originate from natural elements such as measles, coughs or colds (Foster, 1976:775) in which case they are regarded as malwetsi a Modimo (a natural phenomenon). The two are not mutually exclusive, and a natural cause could end up being viewed as of human origin (Devilliers, 1985:49-51).

Culture-bound syndromes

These are considered malwetsi a batho. Among Africans one cannot talk of culture-bound syndromes without implying that the indigenous healer is involved. These diseases are based on African precepts of the world around them and are only understood by Africans. As a result they cannot be cured through western therapeutic techniques (Mabetoa, 1992:61; Karlson & Moloatoa, 1984:27). Consequently, traditional African medicine automatically becomes the healing system of choice. In a study conducted among hostel dwellers in Cape Town it was found that indigenous healers were used for “special conditions
such as idliso, which biomedical healers are considered unable to treat" (Heap & Ramphele, 1991:121; Krige, 1954:60). For this reason the primary role of the indigenous healer is to identify the cause of the health problem or illness and then to determine how best to handle the cause. Until the cause is determined therapy is believed to have little effect. Foster states:

We see in this belief the reason why so often traditional people happily accept the ministrations of physicians but also insist simultaneously on traditional rituals and ceremonies. The physician alleviates the symptoms, but until the ultimate cause is uncovered and dealt with, improvement will be temporary (Foster in Bannerman, et al, 1983:20).

Scientists would not expect a South African black family from the rural areas to mould its lifestyle according to the British or American models. Yet, when it comes to religion those converted to Christianity are expected to simply forget their indigenous religious practices — practices which proved effective with their forefathers — and place the entirety of their faith in western models of medical science. du Toit cautions:

We forget that a person cannot be “born again” in toto where a new basis for belief is accepted or when faith is placed in new curing properties (du Toit, 1980:22).

It is also forgotten that change in one behavioural sphere does not necessarily affect change in every other sphere of thought and action. The motivation for change in one sphere may not necessarily apply for other spheres in terms of belief and action. Healing among blacks is heavily imbued with religious bases enhanced by rituals. The fact that a South African black is a Christian does not exclude him/her from engaging the services of the indigenous healer. This fact is actually supported by the greater support of “healing churches” by a majority of blacks in South Africa. Jahoda found that in many instances the reassurance and support provided by indigenous healers prevents serious breakdowns. The author further states that a similar need is served by the “healing churches” (Jahoda, 1961:268). This type of reassurance is found lacking amongst formal health practitioners.

Mystical causes

When the cause of a disease is thought to be caused by something other than natural the indigenous healer’s services are employed to find out why the illness occurred (du Toit, 1980:32). This type of theoretical explanation is regarded by Horton (1967:60) as a coping mechanism which absorbs the cause while it, at the same time, reduces anxiety. Horton’s statement is supported by du Toit (1980:32) who states that when a system fails to offer explanations anxiety and chaos results, and witchcraft comes in as part of the explanation of the “why” and not the “how” of the occurrence. Such conditions as headache, body pains, influenza, mokholhane, nyoko and diseases associated with old age are, among others, regarded as malwetsi a Modimo (a disease caused by God) and are, therefore, looked upon as natural. Consequently, blacks believe that many of these illnesses can be alleviated or even cured by the administration of natural herbs.
(Gelfand, 1964:28). Depending on one’s beliefs about the existing forces, the nature of a disease/illness and its cause, healing has different implications. Treatment could be directed at both the cause and the disease and should also involve rituals aimed at strengthening and protecting the person (du Toit, 1980:32). Some authors view this type of activity as being no different from rituals performed in some Christian churches or where a priest is called upon to bless a home (Gelfand, 1980:2).

**Witchcraft causes**

Africans believe in the existence of special magical malevolent forces. The belief is that certain human beings have the knowledge and ability to tap into and control these forces (Murdock, 1980:20-21, Mbiti, 1969:200-201; Gale, 1934:748). Sometimes ill health is associated with deliberate actions by malevolent people and creatures (Cheetham & Griffiths, 1976:43; Price-Williams, 1962:123, du Toit, 1980:23). In this category is found witchcraft causes.

Belief in witchcraft is not only typical to South Africa but is also found among the people of Papua New Guinea (Lepowsky, 1990: 1052). According to Swantz and Swantz (1975:310) 90% of illnesses brought to a diviner by the rural Zamaro are attributed to social relationships. Mbiti (1969:26) states that in some African societies people feel and believe that all the various illnesses and misfortunes experienced, including accidents, are caused by the use of mystical power in the hands of a witch or wizard. Tied to this belief is the accompaniment of witches by familiars such as tikoloshe, impundulu, and umamlambo which are believed to attack people and thereby cause ill health (Cheetham & Griffiths, 1982:955).

**Impersonal causes**

Some illnesses are believed to be caused by impersonal actions rather than through human or supernatural forces. For example, a ritually impure woman is believed to leave dangerous tracks and shadows — metlhala, meriti or makgome — wherever she moves; she is regarded as a source of ill health and misfortune and should be avoided (Monnig, 1967:67-68; Devilliers, 1985:50). Since tracks and shadows are found where people and animals are it is believed that wherever people, animals or things go they are accompanied by their shadows (meriti) and leave their invisible tracks behind. It is also believed that gloomy things cast gloomy shadows or leave behind gloomy tracks which may infect those upon whom they fall (Krige, 1954:53). Those aspects which leave gloomy shadows are believed to be death, abortion and pregnancy; and since people affected by these conditions cross roads and rivers the latter are also believed to be the sources of such syndromes (Krige, 1954:53).

In addition there is go fisa (heat) which is used to illustrate both the dynamics and medical principles of traditional medicine. Physical heat is power-loaded with destructive properties and has deleterious effects on everything it touches. As far as the African is concerned the thermodynamics apply in both the physical...
and psychological spheres; therefore the physical and supernatural causes of ill-health are the same (Krige, 1954:55). Heat therefore causes and accompanies ill health and all illness causes the blood to be hot (Tema & Sebego, 1990:45). As such, blood is believed to be a carrier of *madi-mabe* or *senyama* (bad luck) which causes a person to be used as a scapegoat in situations where he is completely blameless (Vilakazi, 1965). Horton views this belief system as a theoretical orientation and states:

What we are describing here is generally referred to as a jump from common sense to mystical thinking. But ... it is also more significantly a jump from common sense to theory (Horton, 1967:60).

Theoretically then, and since the theory is a coping mechanism, the explanation absorbs the cause and reduces anxiety (du Toit, 1980:34). According to the author when a system fails to offer explanations the levels of anxiety rise and chaos prevails; therefore, coincidence and chance cannot be accommodated.

The approach used by formal health practitioners which lays emphasis on the treatment of disease rather than on the ill person is in direct opposition to the approach used by indigenous healers in the treatment of their patients. In view of the multiple factors it employs, the healing model used by indigenous healers to explain the health needs of blacks appears attractive (Forssen, 1982:238; du Toit, 1980:23; Rappaport & Rappaport, 1981:775; Ngubane, 1976:325). These factors are considered to be within the world view of the culture of black people; and the ministrations of indigenous healers consonant with the cultural beliefs of the community (Brownell et al, 1987:36).

The therapeutic group model used by African indigenous healers includes the positions of the people and their relationships to one another, to the environment, to the ancestors and to the mystical forces bringing about pollution in the lives of people. It is within this context that Cheetham and Griffiths (1982:954) mention that the application of western therapeutic methods is inappropriate and, consequently, ineffective when applied to the treatment of not only the Nguni people, but South African blacks as a whole (Brownell et al, 1987:45). Some authors indicate the difficulties faced by western-trained practitioners when dealing with patients in general and with mentally ill patients in particular because of the complicated use of African rituals, which they consider inappropriate to the western model of providing health care (Cheetham & Griffiths, 1980:166).

A pattern is also observed when formal and indigenous practitioners are consulted concurrently: formal health care workers are consulted for treatment of diseases which western medicinal practices have proved successful while indigenous healers are consulted for other health problems. A study conducted in Cape Town showed that there were negative experiences with formal medical care because cancer patients would not present themselves for treatment and care. For example, not one of the respondents knew of any person who had been successfully treated for cancer. They all felt that if they were affected, they would not go for formal medical treatment (Heap & Ramphela, 1991:122). The results of the study also clarify the statement...
that black South African patients present some symptoms for the "white" type of practitioner while a certain group of complaints are reserved for the traditional doctor" (Mokhobo, 1971:113).

In Tanzania the Zaramo consult hospital doctors for the relief of acute pain but will consult indigenous healers for discovery of the cause of health problems and for its removal (Forssen, 1982:238). According to this author this behaviour is due to the fact that African patients do not feel that they are actually well or healthy until they are assured that the real reason for the disease has been identified and dealt with. Swantz and Swantz mention that patients go to the hospital if they believe they have a "European disease", and will go directly to indigenous healers if they believe they have an "African" disease (Swantz & Swantz, 1975:309-312). This is an indication of beliefs in conditions that are purely African in nature and which can only be treated by indigenous healers. Uys (1989:16) regards the use of the two systems of health practitioners by Africans as a sign of the disintegration of indigenous African health care systems and urges the working together of western and indigenous African health care practitioners.

The Cree Indians of North America are often not satisfied with the formal health care system in their country due to its lack of cultural perspective which has meaning for native people (Morse et al, 1991:1365). The authors further state that western health care is expensive and frequently ineffective. This also is true of Africa, especially since there has been little or no progress made in recent years towards reducing either the incidence or the prevalence of many diseases found in developing countries (WHO, 1981:272).

The roles and functions of indigenous African healers are extensive but primary emphasis is placed on their roles as healers and on those procedures used in healing. This kind of emphasis could be misleading because it overlooks primary aspects that are health related. According to Griffiths and Cheetham (1982:959) this emphasis is in line with present technological, chemotherapeutic, mechanistic and laboratory-oriented western medicine. The authors conclude:

that is why even ukuthwasa, ... is being examined in this way by current researchers (Griffiths & Cheetham, 1982:959).

There is a tendency to think, incorrectly, that the search for alternative models of health care is brought about by a permanent scarcity of financial resources (Bichmann, 1979:175). Worldwide, indigenous healers have found preventive, promotive and curative means for healing with specific health problems pertinent to their own countries. The ability of indigenous Zulu healers to treat a variety of conditions such as snake bites, wounds and sprains, fractures, tooth and ear aches, eye conditions, skin diseases, mental illnesses, heart problems, venereal diseases, impotence and infertility are acknowledged (Bryant, 1983). However, expertise in dealing with different types of health problems, be they preventive or curative, may not, because of the migratory nature of the South African population, be limited to a specific cultural group or locality.

The fact that indigenous African medicine is still utilized is proof that indigenous health care is as old as man himself (Dolan, 1973:6). The search for alternative health care models also indicates that formal
health care is probably inadequate for meeting the health needs of all Africans. There is evidence to suggest that a wealth of pharmacological and technical knowledge existed in pre-colonial Africa. There are examples of angiography and wound dressings found among the Masai, improvement in the abnormal lie of babies during pregnancy among the Hottentots, and tooth extractions, treatment and nursing care of skin diseases, application of preventive measures against communicable diseases and caesarian sections amongst the people of Uganda (Bichmann, 1979:175). In the Sudan indigenous healers are used extensively in the control of neurosis and alcoholism (WHO, 1978:10-11). The possibility exists that this knowledge still exists and may be tapped.

Indigenous healers form a primary health care network for 90% of the rural population in developing countries and are considered one of the surest means for the achievement of total health care coverage (WHO, 1975:3; WHO, 1978:14; Schapera, 1970:130; Green, 1980:494; Griffiths & Cheetham, 1982:959; Koumare, 1983:26). Under-utilisation of health services is indicated in a survey of child health and midwifery services in KwaZulu (Raynal, 1983:654). In this study 51% of the respondents used the services of indigenous practitioners. This is an indication of the need to mobilize all human resources to ensure health care in all community sectors, and to close the existing cultural communication gap within the formal health services. Shortage of health care personnel in a situation where the population is increasing combined with cultural communication gaps between the people being served and health care professions are contributory factors to the separate use of formal and indigenous healers (Mankazana, 1976:104-105). Failure to consider the role of indigenous healers may lead to the strengthening of communication barriers to the detriment of those in need of their services (Brownell et al, 1987:45).

In a study in Botswana Staugard found that indigenous healers often treated illnesses that had already been taken to formal health workers (Staugard,1982:221). In the same study 27% of the respondents mentioned preventive care as one of the reasons for consulting indigenous healers. It was also found that if indigenous preventive care was excluded the symptom-list found among those consulting indigenous healers was similar to that observed in those attending formal medical health care facilities. In the same study 75% of those who consulted indigenous healers for communicable conditions such as sexually transmitted diseases and gastro-enteritis reported improvement and satisfaction with the treatment received from indigenous healers (Staugard, 1982, 221).

Since formal health care services are unable to meet all the health needs of blacks consultation with indigenous healers would be a complementary measure in trying to meet the felt health needs of the majority of the population. To illustrate this point Ezeili writes:

The current increase in the rate at which patients leave the hospital system and seek help from prayer houses, religious 'healers' and traditional healers for their health problems, which are not being dealt with within the health care delivery system, suggests that something is missing in this system (Ezeili, 1990:705).
Maternal and Child Health Care

In situations where methods for providing formal health care are not fully accepted by the local people, indigenous healers seem to be the primary source of maternal and child health care. In his study Mankazana (1976) found that in some parts of the Transkei where acceptability of the use of western medical services was low some 60% of all childbirths occurred at home under the supervision of untrained traditional midwives and family members. Kaya, his co-author (1991:4), also mentions that 60% to 70% of deliveries in the rural areas of Tanzania and Zimbabwe are attended to by traditional midwives; and there is no hope that they will stop practicing (DeJong, 1991:12; Ejeckam, 1977:5-6). Harrison (1974:12) mentions a physician who reported the success with which midwives cut the umbilical cord, treat cuts with herbs and within three days “the wound is healed”.

Preventive Health Care

There is no society without beliefs and practices relating to the avoidance of illness. Although the preventive practice measures used are different from those used by western-trained medical practitioners they are equally rational in that they are applied on the basis of what is believed to be the cause of health problems (Foster, et al, 1983:2).

Preventive health is realised in maternal and child health among Africans and herbs seem to be used more to prevent children from contracting specific diseases, especially new-born babies. Monnig (1967:102) mentions the use of lepheko as a preventive measure against those regarded as impure by the community (the bereaved for instance), its purpose being to keep them from entering a room in which there is a newborn. Mutambirwa (1985:283) indicates that there are indigenous healers specializing in fields relating to the treatment of children’s diseases, as well as a variety of prophylactic measures taken against certain diagnosed and undiagnosed paediatric conditions. According to Gelfand (1980:2-3) the attitude of the African towards health, be it preventive or curative, is sensible even though the cause might be attributed to an upset spirit. The author mentions the role of the healer in preventive health among the Shona of Zimbabwe as falling specifically in the prevention of pregnancy, prevention of diseases in people likely to come into close contact with a corpse, creation of a pleasant social environment and protection of crops against thieves.

Two factors are involved in the protective ritual for children. First, accidents do not occur at random (Mitchell, 1965:194) and as a result individual protection is needed. Secondly, newborn babies die readily and need protection. Barker (1973:81) mentions that health and illness are dependent on “the equation of the spirit, the balance which is forever to be maintained by propitiation and ritual”. There is also a strong avuncular-nepotic relationship among blacks and the role of malome in the prevention of diseases among blacks is the other important factor (Barker, 1973:81). All factors need to be taken in consideration to maintain good health.
Indigenous African healing is frequently preventive and more often preventive measures are initiated by the family. Since healers are commonly found within the family they teach other family members the art of healing (Nemec, 1980:5). Referring to the Zulu of South Africa Bryant (1983:7) is supported by Krige (1954) when he states:

He is quite astonishingly learned in the domain of his own environment. It is by no means an exaggeration to affirm that comparatively the average Zulu can boast of a larger share of pure scientific knowledge than the average European.

The use of ritual remains one of the most important aspects of preventive medicine used by black South Africans (Ejeckam, 1977:3). A missionary in Papua New Guinea found that traditional religious practices, such as sacrifices, offered a means of coping which the culture of the missionaries did not offer (Macdonald, 1982:8). The belief is that unless the ceremony is blessed by the ancestors the whole exercise is futile. In the case of illness it is important that a healing ritual be performed to appease the ancestors.

In another study in Botswana, Staugard (1981:13) found that 43% of the indigenous and 40% of faith healers were engaged in preventive and promotive health work. Trouble is forestalled by observing certain taboos or by performing certain rituals such as ukubethelela or go thaya (du Toit, 1971:54; Dennis, 1978:55). Such protection is usually meant to safeguard and could be extended to cattle, seed, crops, ploughed lands and new huts or kraals. Staugard concludes:

... there remains a clear impression, that the structure of traditional medicine and its concepts are permeated by elements which aim to prevent disease and protect individuals against all possible types of accidents. Thus the repertoire of preventive health care activities ... is very comprehensive (Staugard, 1981:13).

It seems that indigenous healers undertake health education and counselling to prevent recurrence of some diseases. Ejeckam (1977:2) states as a matter of fact that indigenous healers recognise the existence of hereditary disorders and advise against marriages which could perpetuate them. It was from indigenous healers that formal health practitioners learned to use oil of chaulmoogra for leprosy (Mead, 1959:47) and Ginchona bark (quinine) from the pre-Colombian Indians of Peru for the treatment of fever (Trotter, 1975:37). Digitalis is reported to have been stolen by Withering as a secret remedy for dropsy from “an old woman” (Trotter, 1975:38) who could not be acknowledged by name. According to Torry (1972:75) the root of rauwolvia was in use in India and Africa long before it came to be known as Resperine. In this respect indigenous healers could be regarded as informal teaching resources for people of different cultures.

Mogoba (1984) and Bodibe (1988) mention that like formal health practitioners indigenous healers use consultation sessions before prescribing medications. They look for the cause of the health problem through divination and then diagnose before applying correct treatment. They also look for advice on the means of preventing recurrence through these same processes (Mbiti, 1969:169). Authors Such as Ejeckam (1972) are of the opinion that the practice of all medicine whether it is practised by healers or formal health workers is the same the world over. The argument is that there is consultation between the patient and the healer.
during which the latter is acquainted with the signs and symptoms of the illness to enable him/her to offer a composite and meaningful diagnosis and treatment (Ejeckam, 1977:2).

Some of the roles that healers could play in AIDS prevention were mentioned by Karim (1993:423). The use of sound waves in the treatment of certain conditions by indigenous healers was documented by Khumalo (1990:163). Credo Mutwa, a renown indigenous healer in the Northwest Province of South Africa, mentions, for example, the use of a special whistle to summon the Basenji dog used to defend their village (Khumalo, 1990:163). Such a whistle is heard by the dog alone and not the human ear. However, when the whistle is blown close to the head of a person suffering from flu, the flu vanishes. According to Mutwa the whistle emits a certain type of sound wave which “somehow destroys the flu-causing virus”. In other words the idea of using sonic waves to fight killer diseases such as cancer and AIDS is now emerging from among the ranks of indigenous healers who are challenging practitioners of western medicine to test these ideas and prove them incorrect. Credo Mutwa is one of those challengers and points out that:

If Professor Sher is serious (about AIDS) why isn’t my idea given a trial? I want the idea to be tested and used to save our people (Khumalo, 1990:164).

In attempts to cope with their illnesses Indians in the village of Sherupur in northern India are known for their use of a complex assortment of common-sense remedies and rituals which they term “village medicine” (Apple, 1960:89). Research conducted by Erasmus in Ecuador showed that conditions such as measles, infected wounds and skin infections are treated at home while conditions believed to be of supernatural origins are taken to indigenous healers (Erasmus, 1952:411-428). The above examples should not be interpreted to mean that the management of health problems by families is central to indigenous African healing (Gort, 1988:71).

It could be that indigenous healers are effective in the treatment of chronic diseases. A study conducted by Mwabu (1986:317) showed that an average of 29.5% of those suffering from asthma and body and joint pains utilized indigenous healers as a source of health care. To effect treatment activities such as cupping and scarification are used on the site of the pain. Further examples offered are of an indigenous healer who treated cases of asthma with a stramonium leaf in the rural areas of Zimbabwe (Gelfand, 1964:57). Also a study conducted in China, over 500 patients with different types of cancer showed that the use of astrologies membranaceous by indigenous Chinese healers inhibits tumour growth (Hui-Lan, 1990:5).

Social Well-being

Indigenous African healers are community practitioners whose basic tenet is botho or ubuntu. The quality of botho is therefore the quality of the social fabric manifest in every human activity oriented towards building a healthy community. Any anti-social behaviour is not in the interest of social well-being (Sebidi, 1988:27). Basic to the services of indigenous healers is the diagnosis and realignment of anxiety-provoking and conflictual interpersonal and/or social relationships. Turner's case analysis of a Ndebu indigenous
healer shows that within a web of intra-village animosities the healer’s primary function is to ensure that individuals are capable of playing their social roles successfully (Turner 1979:262). As health practitioners the aim of the indigenous healer is to restore and maintain social well being (botho) within the society. It is within this context that the World Health Organization’s definition of health becomes relevant; but it is this very aspect of health that is found lacking in formal health care services. It is within the context of botho/ubuntu that indigenous African healers assume their multiple roles of preventing diseases, safeguarding personal and national safety, forestalling national disasters, and improvement of individual and group qualities as well as protection of the people and their property and environment against lightening in order to ensure social stability and prosperity (Mokhobo, 1978; Dennis, 1978; Griffiths & Cheetham, 1982:959). The axiom: *Motho ke motho ka batho* is therefore relevant and applicable to the practices of indigenous African healers.

It would seem that indigenous healers assume much broader, multi-faceted social roles in their communities combining the functions of healing, advising, social integration, social coordination and cohesion, religion and maintenance of the ecosystem into their treatment schedules. The healers’ mediatory role between the ancestors and their descendants is also advantageous in helping to maintain the social and spiritual well being of their clients and their communities (Price-Williams, 1962:130). According to Green and Makhubu (1984:1074) healers know how to allay patients’ fears and can explain why patients are ill and “perhaps even make sense of his problems with his neighbours and family”. These authors perceive this type of therapy as contributing to the reduction of mental stress while simultaneously curing and preventing other types of illnesses.

People at some stage of life cherish strong and negative emotions of envy, hate and malice against others (Hammond-Tooke, 1975:29). Wealth can be a source of envy and insecurity among black people in South African societies in view of the belief that people who are relatively rich are envied by the poor and are therefore targets for witchcraft. One of the roles of indigenous healers therefore is to set the social climate right (Chavunduka, 1972:92). In this respect Booth (1978:91) states that the individual cannot achieve health alone but only as a properly functioning member of the community. The author continues:

> The sickness of an individual is a symptom of a deeper communal malaise. To deal with the symptoms is at most a temporary benefit; real relationships require the re-establishment of right relationships (Booth, 1978:91).

When an individual is considered vulnerable preventive measures are taken during this life crisis. Lloyd Swantz found in his study that 63% of the cases brought to indigenous healers were thought to be caused by witchcraft. The study also showed that while the majority came for protective medicine against sorcery others came for charms or medicines to help them get work, protect their businesses, deal with sexual or marital problems or to help them to succeed in sport, politics, examinations or court cases (Swantz,
1975:311). It is for these reasons that indigenous healers are popular with the people since they provide the type of health services best understood by their respective communities (Gelfand, 1964:66).

The use of medicines by indigenous healers in African societies is not only for the treatment of diseases but for a multiplicity of problems. Crawford states:

... medicine is used not only to cure disorders of the body but to achieve also any end that requires for its success control over forces which could otherwise be uncontrollable. Medicines are used to protect one against witchcraft; to pass examinations; to win the love of an unwilling woman; to see in the dark; to grow crops successfully; to dispel ngozi and ... for any other purpose (Crawford, 1967:103).

Congruent with Crawford's statement above Tanzanians seem to resort to indigenous healers in cases of mental illness and a variety of problems relating to health. These include marital problems, difficulties at work as well as when special needs for protection are felt, when clients feel forced to do so by the spirits, by ritual obligations. They also include legal problems, sexual problems relating to impotence, cases of theft, imprisonment, sport and politics and from a desire to know the future (Forssen, 1982:239). Such use indicates the roles indigenous healers play in not only the curing of diseases but also in the maintenance of total social stability and well-being within the community. In this respect Mankazana (1979:1004) views Xhosa indigenous healers as specialists capable of dealing with specific socio-economic aspects, eg rural economics and social relations such as fame, luck, success and dignity.

In some instances indigenous healers appear to be used in societal decision-making processes. Among Bangwaketse the services of indigenous healers are employed particularly to seek the cause of an inexplicable occurrence, to determine the correct steps to be taken and to bring a doubtful issue to successful conclusion (Campbell, 1968:9). Indigenous healers therefore actively participate in giving advice and making important social decisions, even to the extent of intervening in legal disputes (Harding, 1977:437).

Mokhobo (1971:111) acknowledges healers as specialists but that they do refer their patients to other healers. A study conducted in Nepal showed that indigenous healers are suitable as referrers to formal health care centres by virtue of their knowledge of local disease patterns, their influence on the health attitudes and habits of the people and their more open lines of communication between villagers and health clinic workers (Oswald, 1983:256).

Mental Health Care

Health services cannot be compartmentalised into either physical or mental but should be regarded as a service for human beings with health problems. Hence the importance of the saying: Mens sana in corpore sano (Chamber's Dictionary, 1959). An unhealthy body affects the healthy mind and vice versa. In this regard Oberholtzer writes:

If we regard human beings as big-psycho-social entities it becomes an artificial exercise to apply oneself only to the mental health component of community involvement. Any professional health worker ... capable of improving health related behaviour in a community, is affecting the mental health of such a community (Oberholtzer, 1985:36).
When addressing the many and different aspects of health and health care, it would seem that the involvement of indigenous healers in formal health care is an opportunity for providing equitable health care to the entire population. Research indicates that both western-trained practitioners and indigenous healers are helpful, especially in the field of mental health. In his study of Zulu psychiatric patients to which indigenous Zulu healers and clinical psychologists were therapists Edwards found that although the two entities functioned from different theoretical orientations they both agreed on the diagnosis and treatment of patients, and were seen by patients as being equally helpful (Edwards, 1986, 1273; 1275). Torrey (1972:101) mentions the efficacy of indigenous healers in dealing with mental illness; and Edgarton (1971:259) regards them as psychiatrists.

Research also indicates the consistency and coherence of traditional Zulu medical approaches to illness and healing (Ngubane, 1977; Edwards et al, 1983; Conco, 1972). Ruitz and Langrod (1976:96) mention that the same therapeutic tools used by western-trained psychiatrists and indigenous African healers work for the majority of blacks (Edwards et al, 1983:4) indicates the presence of common elements in interviewing techniques between western and indigenous medical practitioners although there are important differences as well. What is important however is that patients find that practitioners of the two types of health care systems are helpful.

The difference lies in the fact that activities used by healers in the treatment of mental illness are based on socio-cultural values. When black patients come to the formal health care worker they come either with the expectation of being cured or that at least there will be an explanation given about what is wrong or what has caused the problem (Uys, 1986:31). Asuni (1979:33) states that the success of indigenous healers in treating the mentally ill lies in the fact that their techniques are related to the relevant cultural beliefs of the patient. The healer’s ability to state what is wrong to the patient without the latter mentioning the problem is considered therapeutic (Harding, 1975:437; Ruitz & Langrod, 1976:96; Torrey, 1972).

There are suggestions that hospitalization of the mentally ill induces artificial symptoms which do not develop in patients treated in community settings (Yaiyeoba, 1988:181). This suggestion tends to place more emphasis on the influence of tradition on health care in general and on mental health care in particular. Personal communication with Credo Mutwa revealed that mentally ill patients nursed within the white-walled environment of the hospital become more ill than those nursed in an environment with subdued hues. The above is due to the fact that one cannot draw a line between the end of physical illness and the beginning of mental illness (Yaiyeoba, 1988:181). Divination within specific cultural expectations where people vuma in agreement with the diviner seems to be therapeutic in itself. There is no probing into even the most sensitive issues which, due to culture, are never mentioned especially to strangers such as nurses and physicians.
Although there is evidence that indigenous healers play a vital role in the management of mental illness among Africans (Green, 1980:489) the trend seems inclined toward the use of formal health services. There is however no evidence of cessation of the use of African indigenous healers. In a study conducted among the people of Mangaung in Bloemfontein more that a quarter (27%) of the respondents felt that in times of mental illness a sacrifice to the ancestors was necessary and 7% felt that the sacrifice should sometimes be performed (Uys, 1986:31).

There also appears to be drugs known only to indigenous healers that are effective in the treatment of mental illness. Cheetham and Griffiths (1982:956) found that, except for the relief of symptoms through the use of psychotropic drugs, the application of conventional western therapeutic and supportive methods have proved ineffective for the majority of mentally ill black patients. This is due to ignorance and the misinterpretation of cultural phenomena by formal health care practitioners of patients suffering from culture-bound syndromes, eg *thwasa* being misdiagnosed as schizophrenia (Cheetham & Griffiths, 1981:71; Horgaty, 1971).

There is acknowledgement that indigenous African healers play a vital role in the general management of illness among Africans (Green, 1980:489; that the *Sangoma* is already involved in mental health work and in health counselling at primary levels (Gagiano, 1991:55). Such healing ceremonies as *Isiko lentambo* and *Intlombe* (Buhrmann & Gqomfa, 1982:42; Buhrman, 1981:168) bears witness to the fact that treatment procedures reflect a worldwide trend towards holistic health care — care that considers the patient within the context of his community. This holistic approach towards treatment also acknowledges that the mind and body are inseparable. Sanders (1982:175-178) describes a similar phenomenon amongst the Navajo of the United States where healing rites are used to cure physical and mental illness. Of primary importance is that these ceremomial rituals offer meaning to suffering, whether or not that meaning makes sense to the western-trained health worker is immaterial, thus re-enforcing the depth of cultural convictions embedded in indigenous healing techniques (Buhrmann & Gqomfa, 1982:41). Consequently indigenous healers seem to be able to persuade communities to take an active part in the therapy of patients due to their effective use of hope and faith in the treating and curing of illnesses (Frank, 1968:384) which in turn tells us that healing is thus based on the establishment and maintenance of satisfactory relationships between the individual’s beliefs, his ancestors and the spirit world (Harding, 1975:438).

Compared to western-trained health practitioners it appears that indigenous healers devote more of their time to the care of the mentally ill. Observation of Cree Indian healing ceremonies by Morse et al (1991:1364) showed that much time is spent with each patient. The impression one gets of care given mentally ill patients by Yoruba healers is one of painstaking kindness which is in most instances very time consuming (Harding, 1973:201). Reports on African mental health care also indicates that indigenous healers approach their clients with “considerable warmth and sympathy” (Good, 1977:708). In a follow-up...
study of schizophrenic patients discharged from treatment Harding (1973:201) found that 33% of those patients treated by indigenous healers became completely normal. The effectiveness of their treatment was attributed to mutual understanding, based on shared cultural values and norms, between the therapist and patient.

Music and dance are also important aspects of indigenous healing among Africans because of its therapeutic value (Henderson, 1987:90). It is through music and dance that it is possible to invoke the ancestral spirits (Harding, 1977:439). The same use of music is found among the native Indians of North America (Bell, 1994:239); and attendance of any event in which dancing, drumming or traditional singing occurs should be perceived within the context of healing and curing (Burhmann, 1981:90). Some authors write that the dramatic effects of the Intiombe and Xhentsa are because, through these rituals, a person is able to relive events and feelings from the past thus enabling the person to deal with painful situations (Burhmann & Gqomfa, 1982:42). Thomas (1974:1727) has documented the positive effects of music on health; and Robinson states that even today music is set aside for use in the event of illness “and the powerful effect this music has is uncanny” (Robinson, 1983:8).

Buhrmann gives two reasons why certain procedures used by indigenous healers work. The author states that the number one cornerstone of the healer’s success is his knowledge of and faith in the cultural beliefs of his own people. Second is the use of neurophysiological functions initiated through ritual dancing as in the Intiombe and Xhentsa among the Xhosa people of South Africa (Wilson et al, 1980:133). According to the author these have clearly observable effects on the physical well being of a person as well as on the individual’s neurological activity (Buhrmann, 1981:190; 1982:42).

There is general acceptance that chronic conditions such as psychological disorders tend to dominate the field of traditional medicine (Landy, 1977; Kleinman & Sung, 1979). With the control of communicable diseases coupled with increases in chronic conditions such as heart diseases, arthritis, cancer, AIDS and psychosis the continued use of the services of indigenous healers seems to be assured. Good states:

In fact the inability to “cure” these “modern” illnesses as dramatically as curing yaws with penicillin has only gone to increase the frustrations and anxieties of people, thus pushing them to seek other forms of health care. Resorting to traditional medicine is therefore liable to increase rather than decrease (Good, 1977:711).

According to De Jong (1991:6) there is evidence that with modernization the demand for traditional medical services is likely to increase in urban areas in view of the healers’ skills in helping people to cope with both the psychological and social tensions which often accompany economic change. This is supported by evidence that in the treatment of mental illnesses the person most knowledgeable about the patient’s value system is best able to help the patient, and in the majority of cases healers best understand the patient’s problems, beliefs and needs and is therefore likely to be of best assistance (Schweitzer, 1980:280).
Another area in which healing activities occur amongst blacks both in rural and urban areas is in African Independent Churches. Schweitzer (1980:281) mentions that as a result of the disintegration of communities due to rapid urbanization, the therapeutic function of the church lies in its "integrating effects". Since the church movement has links with culturally different groups including indigenous healers (Sunkler, 1960) it serves a prophylactic and therapeutic role by integrating and accommodating those with mental problems (Schweitzer, 1980:218).

**Culture-bound Syndromes**

Indigenous healers are considered useful in the treatment of those conditions that are culture-bound and which formal health care practitioners are unable to treat. In a study on indigenous healing in suburban Johannesburg Farrand (1980:56) found that western medicine either failed entirely to provide a cure for the pre-training symptoms of Thwasa, or that the symptoms returned immediately after the sufferer left hospital. In a study conducted in a big South African city hospital which admits black patients Farrand (1984:780) also found that respondents grouped themselves into those than can be treated by western medical practitioners and those that are only treatable by indigenous healers. In the same study 29.7% indicated preference for treatment by a Sangoma and Moporojiti, and 24.6% preferred both western and indigenous medical practitioners. In another study 40% of respondents mentioned that they would consult practitioners from both health care systems (Farrand, 1984:780). Observations have been made that 70% to 90% of all self-recognised illnesses are managed outside formal health care systems (Kleinman et al, 1978:251).

There are also indications that the utilization of the services of indigenous healers is not confined solely to the less-educated sectors of the population; and that education has failed to change the attitudes and beliefs deeply embedded within African social systems (Cheetham & Griffiths, 1976:44). A study of African cosmological beliefs conducted among medical students at the Medical University of Southern Africa (MEDUNSA) showed persistence of the belief that diseases are caused by evil forces and envious enemies (Elliot, 1981:87-88). Hurst states that contrary to what would be expected professional and middle class people in particular make use of the psychotherapeutic services of witch doctors. The author further states that:

> These visits are kept secret and are denied as they would interfere with the image of the educated bantu (Hurst, 1976:121).

The above statements suggest that traditional cultural beliefs and customs relating to health and illness are still widely held by black South Africans including educated ones (Edwards & Cheetham, 1982:82). They also show that education has failed to change the attitudes and beliefs deeply rooted within the African social system (Eliot, 1981:109). These are also indications that such beliefs cannot be eliminated by the teaching of science and will survive educational processes including university education (Jahoda, 1968:169; Jahoda, 1968:1356; Lepowsky, 1990:1049).
Other studies have also shown that highly educated people living in urban areas use indigenous healers. In a study conducted in Ibadan Nigeria 70% of the highly educated and the poor were found to be using indigenous medical services (Maclean, 1971). The results show that the services of indigenous healers are important to the majority of city dwellers as well. If it were not so, Lloyd Swantz asks:

What then are the 700 medicine men doing in Dar es Salaam, and why do some 800 to 10,000 clients visit them every day, when government services are offered free of charge? (Swantz & Swantz, 1975:311).

In his study Ademuwagun (1976:28) could find no conclusive evidence that the level of education significantly influenced the patterns of utilization of indigenous health services. The significant feature in this study was the dual utilization of both western and indigenous services by both the educated and the illiterate. Rosella et al (1974:243) also noted that cultural beliefs and practices often affect the use of modern health care services regardless of the income or the educational level of the people.

In countries where indigenous healers operate as part of the national health delivery systems the healers’ functions include alleviating manpower shortages and increasing health coverage, meeting those needs unmet by western medicine and bridging the cultural gaps between the two systems of health care (Mankazana, 1979:1004; Harrison, 1974:9). Experiences relating to the utilizing of the services of indigenous healers in ghettos and refugee camps proved to be beneficial in helping people to cope with stress-related illnesses (Heigel, 1984:30; Mdluli & Msomi, 1989:15); and for people with severe mental health problems indigenous healers provided informal community-based services within rehabilitative settings (Anthony et al, 1982:83).

Within the African cultural context indigenous healers are specialist in their different fields. These are boraditlana-tlamalngaka tse tshupja, izinyanga zokwelapha and the senohe/sangoma. In addition there is a wide field of specialization ranging from prevention of hail and lightning to specialising in love charms (Gumede, 1990:99). Their specialist function is illustrated by a western-trained Zulu medical practitioner who states:

My first patient as a young doctor entering practice was a young man who wanted me to face a very serious court case, so that when he speaks with the medicine under his tongue, the magistrate will be influenced to discharge him (Conco, 1991:9).

Utilization of indigenous healers is not confined only to Africa. Civilized Europe uses them. In Finland for example cupping is practised to effect the treatment of headache, hypertension, toothache, neck, shoulder and back ache as well as aching limbs and skin diseases (Vaskilampi & Hanninen, 1982:76).

In the absence of western technology the use of indigenous plants in traditional medicine has proved helpful throughout man’s existence. Although used, sometimes also as food, most herbs used by healers also have medicinal properties and are effective in the prevention and treatment of oral diseases, symptoms of malaria infection and raised blood pressure (Etkin, 1979:395). It is therefore difficult to draw a line between what is food and what is medicine. For instance Kaya and his colleagues (1991) found that many plants used as relishes by blacks in South Africa are known to cure certain diseases. The low levels of scurvy in the low
veld of the Northern Province are attributed to the high levels of ascorbic acid found in the pulp and fruit of the baobab tree (Carr, 1958). Further, analysis of home brewed African beer showed a significant amount of vitamins B and C (Fox, 1974:2339).

In one study 99% of the indigenous Ghanian healers interviewed indicated there was genuine curative powers in herbs for treating specific diseases such as hypertension, epilepsy, jaundice, piles, fertility problems, gonorrhoea and other tropical diseases (Sekyere, 1983:46). In another incident a patient who was described by Berekum hospital practitioners as “hopeless” was referred to a herbalist clinic by the patient’s parents. The medical practitioner was later “shocked” to see the same patient healed and healthy (Sekyere, 1983:46). Because of the acute shortages of medical supplies in developing countries (Agba, 1983:59) the use of local drugs by indigenous healers seems to be the solution. Baku argues in favour of the herbs used by indigenous healers and states:

It is a fact that the side effects from herbal medicines are often less than those of modern drugs (Baku, 1988:9).

Matjile (1989:7) suggests that indigenous healers could contribute to primary health care through their involvement in the education of communities especially in matters relating to the prevention of diseases, disability, dependence, dissatisfaction and death. Considering that among certain ethnic groups formal health workers have no working knowledge of the cultural backgrounds and beliefs, nor the language and customs related to health, of the people they are treating, proper assessment of certain illnesses becomes a disaster (Buhrman, 1977:464); therefore the use of indigenous healers in health care is important. The continued existence of care-giving roles of indigenous healers in today’s ever-changing societies is ascribed to a number of factors. These include some flexibility in adapting to change, having a belief system similar to that of the patient, the healers’ knowledge of the needs of the society and the serious attention given by them to the total person with extended family and the ancestors (Allwood, 1979:43). In South Africa the role of the indigenous healer in primary health care includes the alleviation of manpower shortages, the increasing of health care coverage, meeting the health needs unmet by the western health care and “bridging the gaps in conceptual appreciation of (the) health problems” of blacks in order to increase the appropriate use of health services (Mankazana, 1979:1004). There are arguments that indigenous healers are available, accessible, skilled and resourceful and can be deployed to perform frontline activities of care (Ademuwagun et al, 1979; Mburu, 1977).

While some authors view indigenous African healers and formal practitioners as sharing the common goal of protecting and preserving the health of a community (Warren et al, 1982:1873) others regard their acceptance into the health team as a regression into the Dark Ages. In this respect the reports from hospital-based health practitioners of tragic results due to treatments administered by indigenous healers cannot go unnoticed (Karlson & Maloantoa, 1986:29). Hutchings and Terreblance (1989:64-65) provide a list of toxic Liliiflorae used by the Xhosa and Zulu indigenous healers with fatal consequences. These cases are
indicative of the lack of knowledge about the toxic effects of medicines on the part of indigenous healers. Speaking against the use of the services of indigenous healers a South African-born, western-trained medical practitioner states:

Let us use all the resources at our disposal to wean our Black (and White) patients from the tyranny of superstition (Motlana, 1988:18).

Buchanan and Cane (1976:1138) mention six patients who died at Baragwanath Hospital due to poisoning associated with indigenous healer attendance. Even those physicians who seem to be in favour of indigenous healers have some reservations. It is however also true that in western medicine mistakes do occur with fatal results (Buchanan & Cane, 1976:1138; Solleder, 1974:2365).

The head of Family Medicine at MEDUNSA states that formal medical practitioners have not been successful in finding cures for certain diseases and if modern medical practitioners were effective there would be no need to go to indigenous healers. Yet that same physician is against working with indigenous healers because to him it would be tantamount to playing a game of soccer with two sets of rules (Khumalo, 1988:8). Herein lies clear indication that formal health practitioners are not concerned with the health of the people but are more concerned with the threat posed by indigenous healers in terms of professional competition!

**Summary**

In this chapter literature relating to the role of indigenous African healers in health care has been discussed. The reasons for the use of indigenous healers have been presented. The African world view in relation to life-after-death and the causes of illness have been discussed. Care in relation to maternal and child health, mental and social well being have also been discussed. The following chapter deals with the research methodology followed in this study.
CHAPTER 3
Methodology

Those, however, who aspire not to guess and divine but to discover and know; who propose not to device mimic and fabulous worlds of their own, but to examine and dissect the nature of this world itself; must go to the facts themselves for everything (Sir Francis Bacon).

Introduction
This chapter describes the methodology utilized in this study. A description of the rationale, research design and method of study will be presented.

Rationale
The majority of black South Africans utilize the services of indigenous healers (Gumede, 1990:iii). The new National Health Plan for South Africa (1994:55) makes provision for cooperation between indigenous healers and the formal health sector in the provision of health services. However, no systematic research exists in relation to the role that indigenous African healers play in the prevention of disease and the promotion of health.

Research Design
This study was designed as an ethno-medical, contextual, exploratory qualitative study.

Ethno-medical
It was ethno-medical in that it looked at the health care of a specific group aimed at interrelating with informants in relevant informal conversation and deliberations as well as focused questioning to illicit rich cultural meanings (Parse, Coyne & Smith, 1985: 193).

Contextual
It was contextual in that individuals in a specific cultural group (Tswana) served as samples in obtaining the data.

Exploratory
It was exploratory in that the study intended to explore the depth, the richness and the complexity and increase of insight into the experiences of indigenous healers as health care providers, and generate meaning (Burns & Grove, 1993:16) regarding cultural preventive and promotive care peculiar to the health-illness needs of black people.
Qualitative

The qualitative approach allows the researcher to "... gather data on numerous aspects of the situation and to construct a complete picture ..." (Mouton & Marais, 1993:205). Since each situation is experienced differently by each individual, this approach is suitable as "... it assumes that subjectivity is essential for the understanding of human experience (Burns & Grove, 1993:28). The study was qualitative in that it strived for the best possible understanding of illness prevention, health promotion behaviour and experiences of health care based on cultural beliefs, values and practices. Seaman (1987:169) describes qualitative research as one in which the researcher plans to observe, discover and analyse the characteristic attributes, themes and underlying dimensions of the particular unit. According to Leininger (1985:5-7) the focus is on identifying the qualitative features, characteristics or attributes which make the phenomenon what it is. This includes documenting and fully describing the major features of the phenomenon such as human events, experiences, symbols and rituals under study. It is concerned with gaining insight into the nature and experiences of disease prevention and the health promotion phenomenon of a given cultural group rather than the number of people involved.

The study was conducted over a period of two years from January 1995 to May 1997. In this chapter the following aspects will be discussed:

Population and Sampling Methods

The study was conducted on two groups: indigenous African healers over the age of 21 years who were Tswana-speaking and adult consumers of formal health care services. The latter were located in the clinics indicated in Table 3.

Sampling procedures

Population and sampling methods

The survey was conducted on samples selected within the Northwest Province in the former Bophuthatswana homeland.

Sampling procedures

Selection of the regions

The regions that made up the former Bophuthatswana homeland appear in Table 2. Of the twelve (12) regions of the former homeland, five (5) were selected using simple random sampling. Kudumane, Ganyesa, Odi, Bafokeng and Molopo formed the sample. The distances between the regions necessitated that only five regions be selected.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 3 — Methodology: p.47
Table 2: Regions of the Former Bophuthatswana Homeland

<table>
<thead>
<tr>
<th>NAME of REGION</th>
<th>Molopo</th>
<th>Bafokeng</th>
<th>Odi</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lehurutshe</td>
<td>Moretele</td>
<td>Kudumane</td>
<td></td>
</tr>
<tr>
<td>Ditsobotla</td>
<td>Taung</td>
<td>Thaba Nchu</td>
<td></td>
</tr>
<tr>
<td>Madikwe</td>
<td>Mankwe</td>
<td>Ganyesa</td>
<td></td>
</tr>
</tbody>
</table>

Selection of the healer sample

The first sample was that of the indigenous healers. The criteria for selection were that these healers had to be black residents in the former Bophuthatswana homeland because of the rural nature of the area, and must have practised for a minimum period of five years. A sample of ten indigenous healers was selected using purposive sampling. Two healers were selected from each of the five regions.

Selection of the user sample

A second sample of twelve users of formal health care services in the rural clinics of the already-selected regions was chosen using systematic sampling. Since it was not possible to use a sampling frame to select the sample, number five (5) was selected as a random entry point. Every fifth person leaving the clinic formed the interview sample. Two people were interviewed from each clinic by research assistants.

Selection of the clinics

The clinics appearing in Table 3 were selected from the five selection regions by simple random sampling using a table of random numbers.

Table 3: Rural Clinics Selected by Regions

<table>
<thead>
<tr>
<th>Region</th>
<th>Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Odi</td>
<td>Maboloka</td>
</tr>
<tr>
<td>Molopo</td>
<td>Montshiwa Stadt</td>
</tr>
<tr>
<td>Ganyesa</td>
<td>Ganyesa Health Centre</td>
</tr>
<tr>
<td>Kudumane</td>
<td>Manyeding</td>
</tr>
<tr>
<td>Bafokeng</td>
<td>Phokeng Health Centre</td>
</tr>
</tbody>
</table>
The Research Question

This study was guided by the research question: How do indigenous African healers contribute to health care among South African blacks residing in the Northwest Province?

The question sought to determine, in depth, the role indigenous African healers play in the prevention of diseases among children, adult males and females and within black families. It also sought to discover which aspects of health care they specialize in and how they can best cooperate with formal health care workers. The probing that followed was a result of the respondents' answers. The approach was aimed at getting a clearer picture of the situation. The following communication techniques were used:

- A summary of what the respondent said was stated by the researchers to ensure that there was agreement on the responses. Sometimes the respondent would be asked to reflect on what he/she said. This was done to ensure that respondents meant what they said.
- Clarifying was used to encourage respondents to express themselves freely.

Field Notes

These were made immediately following each interview for purposes of describing the total situation of the interview and to record the researcher's impressions, as well as to ensure that no collateral information was lost.

It was explained to each participant that the interview would be tape recorded in order to explore in depth indigenous health care aspects as performed by respondents. Confidentiality was assured to those who agreed to participate in the study. It was also indicated that all audio-taped information was confidential and would be done away with once it was transcribed.

Pre-test

A pre-test study was conducted twice. The first study was conducted in Thaba Nchu using a structured questionnaire. The questionnaire was found to be unsuitable for this type of study. The responses provided a limited scope for the obtaining of insight into the subject under investigation. The second pre-test was conducted by interviewing three indigenous healers in the Ditsobotla region. The purpose was to identify any obstacles that could be encountered in this type of research. The question was then phrased as follows: Explain to me how indigenous healers contribute to health care among South African blacks? The second pre-test was found to be effective.
Development of Research Instrument

No structured interview schedule was developed. The question, *Explain to me how indigenous healers contribute to health care among South African blacks*, was used to give researchers direction in the study.

Training of Research Assistants

Two third-year students undertaking a Bachelor's degree at the University of the Northwest were employed as research assistants and trained as follows:

- Qualitative research methods were fully explained to them.
- The research question and sub-questions were discussed with them. For ten days daily one-hour meetings were held with them to discuss problems that might have occurred.
- Where possible they attended the co-promoter's consultation sessions with the researcher to gain full understanding of qualitative research methods.
- A workshop on qualitative research methods was attended with them.

Ethical Considerations

In order to proceed with this study permission was obtained from the provincial Department of Health and Developmental Social Welfare (see Annexure 6). Consent was also obtained from the indigenous healers and the users of formal health care services. Anonymity was assured by the researcher and refusal to participate was explained.

Sponsorship

The decision to undertake this study was the choice of the researcher. Sponsorship had no influence or input in this regard. The loyalty of the researcher is therefore only to the informants.

Researcher/informant relationship

Divination sessions between the healers and the researcher were attempts to make all of the research as transparent as possible for the purpose of maintaining an equal relationship between the informants and the researcher. Being open, informing the respondents of their rights and possible time inconveniences assisted in achieving equal relationship. Informants were shown how to switch the audio-tape on and off if they wished to do so during interviews. Information relating to the handling of raw data was explained to all informants, including the possible people to access it.
Informed consent

This aspect was undertaken to ensure that respondents agreed to participate in the study without being coerced or deceived and without any form of constraint (Burns & Grove, 1993:104; Wilson, 1989:8). The following was communicated to respondents to ensure that informed consent was complete.

Purpose during first contact

The respondents were told of the intent to involve them during the first contact. Information on the purpose of the study, the benefits to the researcher and the possible intermediate and long-term benefits for the healers and the community was communicated to them (see Annexure 4). The expected duration of their participation in the interview was also indicated. The procedures to be followed in an in-depth interview (60 to 75 minutes) were explained. The respondents were given the right to choose the setting for the interview.

Collection of Data

Data was collected between April and July 1996. Unstructured, free-type individual interviews were conducted to collect the data. Indigenous healers were interviewed by the researcher, and the users of health services were interviewed by the research assistants. Tape recorders were used to record the responses. A camera was used to capture those life experiences that could not be recorded on tape. Field notes were taken at every interview session.

Each interview was transcribed within twenty-four hours for purposes of extraction-synthesis. Burns and Grove (1993:579) view extraction-synthesis as:

a process of moving descriptions from the language of participants up the level of abstraction to the language of science.

Since the study required interpersonal interaction, the researcher introduced herself to each healer by first asking for a divination session before the start of an interview. After the session an appointment for an interview was made. This approach assisted in enabling each of the healers to become better acquainted with the researcher and to develop rapport between the healer and the researcher. The researcher was however aware of her personal perceptions, beliefs and values. According to Munhall and Boyd (1993:187) this kind of awareness assists in understanding the world of informants. Berger and Kellner (1981:50) states:

If such bracketing (of values) is not done, the scientific enterprise collapses, and what [the researcher] then believes to perceive is nothing but a mirror image of his own hopes and fears, wishes, resentments or other psychic needs; what he will then not perceive is anything that can reasonably be called social reality.

Of the ten healers five agreed to be interviewed on the day of initial contact. The other five were interviewed on separate dates. Each interview lasted for about one hour and fifteen minutes.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 3 — Methodology: p.51
The total number of kilometres travelled to the different regions in the province amounted to 3210. Another 3210 km was completed during the validation of data.

**Limitations of the Study**

In conducting this study the privacy of informants could have been invaded. The fact that traditional medicine is a closed field of practice could have influenced the respondents to withhold some information considered highly confidential by the respondents. Therefore the possibility that there could have been selective giving of information by respondents cannot be overlooked. The respondents nevertheless invested their time, knowledge and wisdom while participating in this study.

Group focus interviews could have yielded better results. Although this approach was planned for, the healers did not agree. Their rights had to be respected.

The sample was small and could not allow for generalization of the findings to other South African provinces.

The distance involved between the different areas was too great; but funds were not available for the coverage of other areas. This could have affected the generalization of findings.

**Data Analysis**

Leininger’s Trans-cultural Care Model formed the point of departure for purposes of identifying categories in the analysis of data. Leininger (1978:88) cites nine major categories through which cultural care can be assessed (see Figure 2 in Chapter 1). All nine were utilized in the analysis. To ensure reliability regarding data analysis the assistance of peers was engaged to assist in the examination of transcripts and field notes.

Tape recorded interviews were transcribed word for word in Setswana and then coded. Data were grouped into themes and analysed. Analysis was conducted according to categories by first reading through the transcribed interviews. The units were then encoded by underlining all key words and themes used in the transcription. The words and themes were then classified into categories according to Leininger’s model.

For co-coding use was made of two Tswana-speaking experts in the Department of Setswana of the University of the Northwest. Each expert was given a copy of Leininger’s model with written instructions on the coding and analysis of data (see Annexure 3). Thereafter two nurse researchers in the Department of Nursing Science at the University of the Northwest familiar with qualitative research methods met to discuss the results until consensus was reached regarding categorization.
Quantification of Results

From the participants’ transcribed verbal reports of their knowledge of indigenous health issues results were prioritized according to the number of responses identified. Similar responses were then grouped together.

Description of the Results

For purposes of description, half (5) similar responses to a phenomenon was seen as significant because the total number of participants were ten (N=10). However, since one might have repeated a theme, the number might be more. No information was omitted. However, only themes which appeared five times or more are discussed in detail.

Reliability

Reliability in a qualitative study is judged by whether an independent researcher could generate the same information in a similar situation or could place the data in the same previously-generated constructs (Woods & Catanzaro, 1988:157). Areas identified as potential threats to this study were controlled to increase reliability. They were identified as follows:

- The status of the researcher. Since traditional healing is regarded as a family heritage that should not be disclosed to strangers the information shared is often of a confidential and sensitive nature.
- The first contact with the healer was devoted to acquainting the researcher and interviewee with one another and to building a relationship of trust between the healer and the researcher. This was done by first requesting a divination session in which the healer divines the researcher.
- The researcher, though a professional nurse, was dressed in traditional civilian clothes in order to avoid identification with the western system of health care. Thereafter the researcher clearly identified herself as a student of the University of South Africa and her role as a student in the research setting. This strategy was found to be acceptable to the participants.
- Since replication of qualitative studies is not possible and since constant comparative analysis could have resulted in disagreements on the composition of events or constructs of the interview it was possible that the method of procedure could pose a threat. This was overcome by delineating the context in which data was to be generated by using the categories of the transcultural assessment as follows:
  - explanation of the processes involved in the decisions to participate in the research;
  - tape-recording of all interviews in order to ensure accurate recall of their contents;
  - precise and thorough reporting of the strategies used to collect, analyse and code the data;
  - verbatim transcribing of the tape-recorded interviews; and

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 3 — Methodology: p.53
• consultation of nurses well-vested in qualitative research methods.

Validation of Data

According to Leininger (Brink, 1991:16) validity is assured by providing insight, knowledge and understanding of meanings, attributes and characteristics of those under study. It is concerned with the true value of findings. In this study validity was assured by:

- selecting participants who met the criteria for the sampling technique;
- informing the participants that they are the experts in the topic under study;
- using triangulation to validate the data as follows:
  - using a panel of coders to audit the raw data; and
  - comparing analysis and validity checks with participants with the researcher going back to the healers to verify that the transcribed information was correct.

Summary

In the previous section literature relevant to this study was discussed. This chapter dealt with the manner in which the study was conducted. The procedure followed for conducting the study is explained. In the next chapter the results are presented and analysed.
Introduction

Chapter 3 described the manner in which this study was conducted. In this chapter the findings of the collected data are analysed. The English version of the identified themes will be used in order that these experiences will be more widely understood. The findings will be discussed based on Leininger’s (1978) model of trans-cultural assessment domains. In this study, if a theme occurs five times or more, it will be considered significant and will be discussed. Themes that occur less than five times will be reported but not discussed.

Terminology Related to Cultural Health Care

Since this study was conducted in an area populated mainly by Batswana certain terms related to Setswana health care were consistently used by the participants in this study. Explanation of these terms is done in this section so as to clarify their meaning within the context of this study.

- **Go thaya/tiisa motse**: Batswana have their own strategies for dealing with health problems one of which is to strengthen or to fortify the family. Batswana believe that people with evil intentions could cause harm to one’s family through witchcraft. *Go thaya motse* is a strategy related to prevention of witchcraft and disharmony within the family. In this preventive activity the indigenous healer plants pegs in the four corners of the house or yard before a house is erected. The measure is primarily used to prevent witches from entering the household. The belief is that once this is done husband and wife will never divorce each other, witches will be unable to enter the household, children will grow uneventfully and the family will live in harmony.

- **Go Thapisa**: A health ritual performed before or after go thaya but on the same day. The term refers to the cleansing of the homestead and its inhabitants. It is believed to cleanse any witchcraft that might have been practised on the spot, and it is believed to strengthen the pegs used during go thaya. The ritual is also performed in cases where witchcraft is believed to have been practised in the family. The ritual is performed using a flail, usually the tail of an antelope.

- **Go tswa ka soba la magodu**: This is a Setswana ritual performed in instances when a woman conceives but has repeated miscarriages or where children born of her die after birth. The ritual

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1 *Go thaya kgotsa go tiisa motse.*
2 *Dimapo.*
3 *Seditse.*
is performed at night with the couple naked. It is performed at the home of the affected woman. The father of the woman provides a sheep. The healer makes a hole through the stomach of the slaughtered sheep so that married couple in question go through the cut hole in the stomach. The healer ensures that part of the stomach touches their backs as they go through the hole of the stomach while running to their room. In the room is the aunt of the woman who applies medicines on the two participants. The ritual is believed to stop abortions, miscarriages or children from dying. An avuncular relationship to the treatment of diseases is indicated in this ritual and is because of the belief that specific people in the family can treat certain conditions and heal them. An aunt or uncle are counted among such people.

- **Moparego/Mophakwana:** This is a stick which is placed at the entrance of the room where the delivered mother and baby are accommodated. It can also be put at the entrance of a room accommodating a very sick person. The stick serves to indicate that the occupants of the room are in isolation. Only trusted family members are allowed to enter. Young men and women who are sexually active are not allowed to enter because of the belief that they are sick and could infect the mother and the child.\(^4\)

- **Borathane:** This is a health condition believed to arise from breast-feeding a child while pregnant. The child becomes thin, is unable to suck properly and vomits and is termed *serathane.* The mother’s milk is believed to be dirty causing diarrhoea and vomiting. The clinical symptoms are listlessness, malnutrition and stunted growth.

- **Go gatoga ditao:** This literally means to move away from one’s bed. The belief is that a very ill patient sometimes becomes cured if nursed away from familiar surroundings. The patient is removed to either the relative’s home to be nursed there or is taken to *diagelong.*

- **Diagelong:** A place where healers keep their very ill patients who cannot be treated at home due to the seriousness of the condition. It is also a place where trainee healers stay for their period of training. It is a “hospital” for indigenous healers.

- **Dipitsa:** This term refers to a medication — usually more than one herb — that patients or clients drink

- **Boswagadi/makgoma:** This is a sexually transmitted condition believed to arise from the death of a spouse. The belief among Batswana is that phenomena such as death or abortion carry with them diseases called *methala.*\(^5\) A man who has sexual intercourse with such a woman contacts this condition. *Go kgoma* is a Pedi and Tswana word literally meaning “to touch” or “come in contact with.”

\(^4\) *Go okama.*  
\(^5\) The literal meaning of *methala* is “tracks.”
• **Go baya botsetsi:** Botsetsi is *puerperium* or the period of two weeks after delivery. In Setswana it is not less than three months. This phrase means to look after the delivered woman. One of the family members looks after the delivered mother and baby throughout the three months while the mother and baby are resting and recuperating.

• **Go bea ngwana fase:** This phrase literally means “to put the child on the floor”. Setswana culture allows a baby to be picked up by anybody who is not ill. When a baby has not yet received preventive treatment it is given to the widow by putting it on the floor. This behaviour is due to the belief that a widow in black is ill and may infect the baby with *makgoma*. Putting the baby on the floor prevents the baby from being infected.

• **Mopakwana/Lepakwana:** This is the name given to a stick that is placed at the entrance as a warning to outsiders that the newly-delivered mother and baby are in isolation. Outsiders are warned in order to prevent them from entering the lying-in room and infecting the mother and child.

• **Ditanyane:** A herb given to a pregnant mother and to the baby before and after birth to facilitate the growth of the baby.

• **Go se bone thari:** Batswana use a lot of euphemisms. As a result it is almost unheard of to call certain things by name. *Go sa bone thari* refers to childlessness or sterility. The process of treating a sterile women is termed *go bofela*.7

• **Seromo:** This term refers to sores that do not heal. The belief is that they are culture-bound and will heal only if treated culturally, usually by an aunt or an uncle.

• **Serunya:** The literal meaning of the term is a mole. In this case the term refers to the metastatic nature of a tumour which resembles the burrowing activities of a mole.

**Beliefs Related to Health Care**

The data show that the Batswana have a cultural health system which is deeply embedded in their beliefs which emerged from the data are presented in the following pages.

**Womanhood**

First is the belief that there are people with malicious intentions within the society. The belief is that if such people are capable of stealing one’s underwear or sanitary pads during one’s menstrual period and bewitch it so that one may be unable to conceive. If one has conceived one may have a prolonged and difficult labour and may die of obstructed labour. Batswana further believe that people with malicious intent

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6 *Ke moswagadi, o na le boswagadi.*
7 *Meaning “to tie for”.*

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Chapter 4 — Analysis of Data: p.57
can “tie-up” one during pregnancy so that labour could be difficult, prolonged and even obstructed resulting in maternal death. It is for this reason the woman in labour is subject to herbal medications.

**Malignant Tumours (Cancer)**

There is a belief among the Batswana that cancer is caused by witchcraft and that it is both treatable and curable. There is also a belief that disease can be thrown into the hole of an anthill so that it will not recur. The healer, the patient and his or her family go to the anthill and perform a healing ritual there literally telling the disease to go into the hole and never return to the victim.

**Kokamo/Mogato**

The belief that one (specifically the widowed, those in early pregnancy, those having aborted and the promiscuous) can cause illness in children due to their lack of observing cultural taboos. For example it is believed that indiscriminate sexual intercourse and not observing the cultural taboos after abortion, during puerperium or pregnancy may result in infants becoming ill or dying.

**Sefifi**

There is a belief among Batswana that people with bad intentions can cause one to have bad luck. Sometimes bad luck is believed to occur as the result of coming in contact with the wrong people. Such people bring with them bad luck or sefifi, and include widows and people with a history of recent abortion.

**Sejeso**

There is a belief that people with bad intentions can give one some poisonous substance in food. The term is derived from the very sejeso and refers to a poisonous substance that has been eaten.

**Dikgaba**

In Setswana people must not think negatively about a person especially family relations. If they do a person is likely to have bad luck in whatever he/she does. Dikgaba always has negative connotations and indicates that all may not go well with a person, eg if a woman is pregnant the child may die during delivery.

**Analysis of Data**

A culturologic assessment is used as the basis for the analysis of findings (see Table 4).

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8O gata bana, kgotsa o a ba okama.
9Batho ba sa siamang.
10Literally meaning “to make to eat”.

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Chapter 4 — Analysis of Data : p.58
### Table 4: Leininger’s Culturologic Assessment Domain

<table>
<thead>
<tr>
<th>Assessment Domain</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Individual or group pattern of life-style</td>
<td>1.1 Health maintenance behaviour</td>
</tr>
<tr>
<td></td>
<td>1.2 Illness behaviour</td>
</tr>
<tr>
<td>2. Cultural norms, values and individual or group expressions in relation to health care behaviour</td>
<td>2.1 Observed or stated values regarding health care and caring</td>
</tr>
<tr>
<td></td>
<td>2.2 Observed or stated norms, values and behaviour regarding health care and caring</td>
</tr>
<tr>
<td>3. Cultural taboos and myths</td>
<td>3.1 Stated beliefs and values relating to taboos (proscribed thoughts)</td>
</tr>
<tr>
<td>4. World view and ethnocentric tendencies</td>
<td>4.1 The people’s view of health</td>
</tr>
<tr>
<td></td>
<td>4.2 The people’s view of illness</td>
</tr>
<tr>
<td></td>
<td>4.3 The people’s view of care givers</td>
</tr>
<tr>
<td></td>
<td>4.4 The people’s view of the receivers of care</td>
</tr>
<tr>
<td>5. Cultural diversities, similarities and differences</td>
<td>5.1 The people’s different health, illness and treatment beliefs, values and practices</td>
</tr>
<tr>
<td></td>
<td>5.2 Reasons for cultural differences</td>
</tr>
<tr>
<td>6. Life caring rituals and rites of passage</td>
<td>6.1 Health/illness related rituals, ceremonies and treatment</td>
</tr>
<tr>
<td></td>
<td>6.2 Rituals and ceremonies related to cultural movement from one position to the other, or achieving a different position or status</td>
</tr>
<tr>
<td></td>
<td>6.3 Functions served by rituals in a given culture</td>
</tr>
<tr>
<td>7. Folk and professional health-illness cultural systems</td>
<td>7.1 Indigenous or local curers and carers</td>
</tr>
<tr>
<td></td>
<td>7.2 Indigenous healing/curing and caring methods, and description of illness</td>
</tr>
<tr>
<td></td>
<td>7.3 Professional formal health care system</td>
</tr>
<tr>
<td></td>
<td>7.4 Benefits of indigenous caring and curing systems</td>
</tr>
<tr>
<td>8. Specific caring behaviours and nursing care values, beliefs and practices</td>
<td>8.1 Support systems</td>
</tr>
<tr>
<td></td>
<td>8.2 Role of support systems, ie activities</td>
</tr>
<tr>
<td>9. Cultural changes and acculturation aspects</td>
<td>9.1 Extent to which indigenous culture is supported (by one)</td>
</tr>
<tr>
<td></td>
<td>9.2 Extent to which a new way of life is adopted (by one).</td>
</tr>
</tbody>
</table>

In analysing and grouping the data similarities interrelationships and overlaps were identified. Where these occurred, the domains were combined and interrelationships discussed. Domains number one and two deal with observed and stated behaviour. In view of the overlaps and interrelationships within these domains, the two will be discussed together. Since domain 9 overlaps with all other domains it has not been discussed separately.
Domain Number 1: Patterns of Life-style of an Individual or Cultural Group

Table 5: Domain Number 1: Patterns of Life-style of an Individual or Cultural Group

<table>
<thead>
<tr>
<th>Assessment Domain</th>
<th>Categories</th>
</tr>
</thead>
</table>
| 1. Pattern of life-style of individual or cultural group| 1.1 Health maintenance behaviour  
|                                                        | 1.2 Illness behaviour     |

Data relating to the pattern of life-style of the individual or group about health maintenance and illness behaviour was obtained through observation and some values were expressed orally. Observations were made in the homes of indigenous healers and in the natural environments within which activities took place in order to obtain accurate information about the health constructs. Themes identified from the data have been classified according to expressed activities (see Table 6).

Table 6: Expressed Patterns of Life-style

<table>
<thead>
<tr>
<th>Category</th>
<th>Theme</th>
<th>Activities</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Health maintenance</td>
<td>Disease and accident</td>
<td>Divination and home</td>
<td>10</td>
</tr>
<tr>
<td>behaviour</td>
<td>prevention</td>
<td>fortification</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fortification of individuals</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cleansing of individuals</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Divine the day or journey</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nutrition</td>
<td>5</td>
</tr>
<tr>
<td>1.2 Sickness behaviour</td>
<td>Health maintenance</td>
<td>Divination</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Health screening</td>
<td>Oral medicines</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Treatment</td>
<td>Induced vomiting</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicinal enema</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cleansing rituals</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sacrificial offerings</td>
<td>5</td>
</tr>
<tr>
<td>Ancestral relationships</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N=10

Sickness Behaviour

Six themes appeared under Sickness Behaviour and are described in the following paragraphs.

Health screening

Divination appeared in all ten informants. Different methods of divining were mentioned. One informant mentioned a combination of diving methods using bones and *mankgonyana*.¹¹

¹¹*Mankgonya* means a joined wooden structure controlled by hands.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Chapter 4 — Analysis of Data: p.60
Treatment

Oral medicines, induced vomiting, enemas and scarification are considered significant methods of treatment in that they appeared five times. Cupping appeared three times.\textsuperscript{12}

Relations between the ancestors and the living

Maintenance of good relations between persons and their ancestors was identified as a theme. Sacrificial offerings and ritual cleansing appeared five times. These also appear in Domain Number 6: Life Caring Rituals and Rites of Passage.

Training

The training of \textit{thwasa} initiates as a form of treatment occurred four times. Although this theme is not considered significant it is important in that suffering from \textit{badimo} is a culture-bound syndrome. The call to \textit{thwasa}\textsuperscript{13} is considered important in the treatment and cure of the symptoms related to \textit{badimo}.

Prevention of diseases and accidents

Cleansing and fortification of homes and persons as a means of preventing diseases and accidents ranked high. Divining the events of the day or the success or failure of a trip appeared three times.

Nutrition

Good nutrition was mentioned five times and was considered significant in the prevention of diseases and promotion of health.

Table 7 shows the observed patterns of the life-styles of individuals or groups and should be read in relation to the expressed patterns of life-styles (see Table 6) and information on field observations.

\textsuperscript{12}The term "cupping" refers to tapping blood from the body using a funnel-shaped receptacle.
\textsuperscript{13}\textit{Thwasa} means "to become a healer".
Table 7: Observed Patterns of Life-style

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
<th>Activities and Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Health maintenance behaviour</td>
<td>1 Disease and accident prevention</td>
<td>1. Divine and fortify home 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Cleanse persons 6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Divine day/road 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Fortify persons 10</td>
</tr>
<tr>
<td>1.2 Sickness behaviour</td>
<td>1.2.1 Health maintenance</td>
<td>1. Good nutrition 5</td>
</tr>
<tr>
<td></td>
<td>1.2.2 Health screening</td>
<td>2. Divinations 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Bone throwing 8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Tea leaves 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>○ Bible 1</td>
</tr>
<tr>
<td></td>
<td>1.2.3 Treatment</td>
<td>1. Oral medicines 10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Induced vomiting 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Enema 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Scarification 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Cupping 3</td>
</tr>
<tr>
<td></td>
<td>1.2.3 Good relations between the living and the ancestors</td>
<td>1. Offerings 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Cleansing rituals 5</td>
</tr>
<tr>
<td></td>
<td>1.2.4 Training</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Treatment and training of thwasa initiates 4</td>
</tr>
</tbody>
</table>

N=10

Domain Number 2: Cultural Norms, Values and Individual or Group Expressions in Relation to Health Care Behaviour

Falling within this category are the specific cultural values, norms and expressions of clients or groups regarding health and caring behaviour in their culture. The constructs are obtained through observation. Some are expressed orally and in writing. In this study constructs were obtained through oral information from informants. Categories found in this domain appear in Table 8. Expressions in the table are a literal translation of the transcriptions from the informants and no attempt was made to give any explanation in the table. Some expressions are written in the language of the informants for lack of proper English words and or expressions. Explanation of these will be done in the following section.

Cultural Healing Values

All informants expressed values relating to indigenous healers and healing. Expressions used by some informants were: “It is our culture”, “Our people suffer from cultural diseases”, and “It is cultural treatment”.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 4 — Analysis of Data: p.62
Prevention of Diseases and Promotion of Health

All ten informants mentioned prevention of diseases and promotion of health. Information shows that preventive and promotive health measures are divided into the following categories:

- **Family preventive measures:** These included fortifying and cleansing the home.\(^{14}\) Prevention of lightening appeared three times.

- **Prevention of diseases in children:** All informants mentioned prevention of diseases in children. Prevention included *go bea phogwana, go bea ngwana fase* and *go bea mopakwana*.

- **Strengthening the body:** All informants mentioned that people must be strengthened in order to prevent themselves from being bewitched.

- **Fortifying and cleansing homes and cattle posts:** This appeared as another preventive aspect against witchcraft. Cattle posts and cattle were mentioned due to the idea that cattle are a strong source of the economic power base. Fortification and cleansing of cattle posts also appears in Domain Number 1: Patterns of Life-style of Individual or Group.

- **Drinking medicines for *boswagadi***: This aspect refers to taking oral preventive medicines after the death of a spouse to prevent a sexually transmitted named *boswagadi*.

- ***Go tswana ka soba la mogodu***:\(^{15}\) The activity is engaged to prevent repeated abortion and miscarriages. One literally goes through a hole made in the stomach of a slaughtered sheep.

Treatment of Diseases

Expressions of values in relation to treatment and cure of diseases were identified in all responses. The theme “treatment of diseases” was mentioned but no specific disease was mentioned. Specific treatments mentioned were removing *sejeso* and *sefifi* as well as treatment of fractures. Massage and administration of enemas were also mentioned. Themes in this category also appear in Domain Number 7: Folk and Professional Health-Illness Cultural Systems.

Non-interference by Witchcraft

Non-interference by witchcraft in one’s life appeared eight times and is considered significant. Expressions relating to this theme were, “keeping the witches away, removing *tokolosi* and cleansing homes”. This theme appears in Domain Number 4: People’s World Views and Ethnocentric Tendencies.

\(^{14}\) *Go thaya le go ihapisa leagae.*

\(^{15}\) Literally means “going through a hole in the stomach”.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 4 — Analysis of Data : p.63
Promotion of Physical and Mental Well-being

Ensuring correct and lasting marriages occurred three times. The theme is considered insignificant in terms of analysis criteria in this study. In view of the current divorce rate however the them is considered important and will be discussed together with family preventive measures.

Values regarding health care were identified from informants. Identified themes are listed in Table 8.

Table 8: Observed or Stated Values Regarding Health Care
(See Table 4)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Expressions</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1.1 Cultural healing values</td>
<td>1. It is our culture</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Suffer from one's cultural illness</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Cultural treatment</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Setswana treatment</td>
<td></td>
</tr>
<tr>
<td>2.1.2 Prevention of diseases and promotion of health</td>
<td>1. Go bea phogwana</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Immunize (go soutisa)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Go bea ngwana fase</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Go tswa ka soba ia mogodu</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Fortifying homes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Prevent witchcraft</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Cleanse the home</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Fortify a cattle post</td>
<td></td>
</tr>
<tr>
<td></td>
<td>9. Strengthen the body</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. Lepakwana</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Give a child ditanyane</td>
<td></td>
</tr>
<tr>
<td></td>
<td>12. Go bea botsetsi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>13. Go nwa dipitsa tsa boswagadi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14. Prevention of lightning</td>
<td>3</td>
</tr>
<tr>
<td>2.1.3 Treatment of diseases</td>
<td>1. Remove sefifi</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Take out sejeso</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. Give enema</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Massage</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Treat diseases (not specified)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. To treat fractures</td>
<td></td>
</tr>
<tr>
<td>2.1.4 Non-interference by witchcraft in one's life</td>
<td>1. To keep away witches</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>2. To remove Tokolosi</td>
<td></td>
</tr>
<tr>
<td></td>
<td>3. To cleanse the home</td>
<td></td>
</tr>
<tr>
<td>2.1.5 Promotion of physical and mental well-being</td>
<td>1. Family members should be people</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. They should not become imbeciles or confused</td>
<td></td>
</tr>
<tr>
<td>2.1.6 Promotion of social well-being and family stability</td>
<td>1. Ensuring sustainable marriages</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2. Preventing witchcraft within the families</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3. Prevention of divorces</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>4. Help people to find jobs</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5. Ensuring uneventful ceremonial gatherings</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>6. Treat sterile women</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>7. Treat impotence</td>
<td>8</td>
</tr>
</tbody>
</table>

N=10
Cultural Healing Values

All informants expressed values toward indigenous healing. Examples of expressions used were, “It is our culture”, “People suffer from cultural illnesses”, and “It is Setswana cultural treatment”. These expressions are all value-laden.

Prevention of diseases and promotion of health

All ten informants mentioned prevention of diseases and promotion of health. Expressions show that preventive and promotive health work is divided into categories:

- **Family preventive measures**: Measures include fortifying and cleansing homes. Measures aim at preventing witchcraft in the home. Prevention of lightning appeared three times.

- **Putting a baby on the floor**: In most black cultures a newly born baby is given to everybody. If a baby has not yet received cultural preventive treatment however it is given to a widow by first putting it on the floor for the widow to pick up. The belief is that a widow/widower has *boswagadi* and that putting the baby on the floor prevents the child from being infected from the disease.

- **Lepakwana/mopakwana**: Lepakwana is a stick that is smeared with medicine and placed at the entrance of the room where the mother and baby are accommodated. It serves as a warning to outsiders that the occupants of the room are in isolation. The belief is that people coming from outside the family may have infection and could infect the baby.

- **Ditanyane**: A medicinal herb given to the mother during pregnancy and to the baby after birth to assist in the physical growth of the child.

Strengthening the body

All informants mentioned the need for people to be strengthened against the vulnerability to witchcraft.

Fortifying and cleansing homes and cattle posts

This was mentioned as another aspect of prevention against witchcraft related to the homestead. Cattle and cattle posts were mentioned as sources of economic wealth highly susceptible to attack by witchcraft as a result of malicious envy. This aspect appears in Domain Number 1, Patterns of Life-style of Individual or Group.

---

16 *Go thaya le go tlhapisa legae.*

17 A disease of widows or widowers.
**Drinking the herbs of boswagadi**

Medicines are given to the remaining partner after the death of a spouse before he/she engages in sexual activity after the burial of a spouse. The aim is to prevent the *boswagadi* disease from invading the remaining spouse so he/she will not infect the next sexual partner.

**Go tswa ka soba la mogodu**

This literally means “going through the hole in the stomach” of a slaughtered sheep to prevent repeated abortions and miscarriages.

**Treatment of diseases**

Expressions of values relating to the treatment and curing of diseases were identified in all responses. Although treatment of diseases was mentioned it was not specified which diseases are treated. Specific diseases mentioned were *sejeso,* \(^{18}\) *sejiji* \(^{19}\) and treatment of fractures. Massage and administration of enemas were mentioned. Themes in this category also appear in Domain Number 7, Folk and Professional Health-illness Cultural Systems.

**Non-interference by witchcraft**

Non-interference by witchcraft in one’s life appeared eight times and is considered significant. Expressions relating to this theme were “keeping witches away, removing *tokolosi* and cleansing homes”. The theme also appears in Domain Number 4, People’s Views and Ethnocentric Tendencies.

**Promotion of physical and mental well-being**

This theme occurred in all ten responses. Expressions were mentioned about physical and mental well-being in relation to non-interference through witchcraft in one’s life. Expressions indicated the preventive aspects such as: preventing family members from becoming imbeciles or confused and ensuring that they remain normal thinking individuals.

**Promotion of family and social well-being**

Emphasis in the theme was on ensuring marriage of “correct people” or couples whose families do not bewitch, and prevention of divorces. Ensuring correct marriages appeared three times. In terms of the analysis criteria this theme is insignificant. However in view of the numbers of divorces within families it is important and will be discussed together with family preventive measures.

\(^{18}\)Swallowed poison.

\(^{19}\)Bad luck.
Values and Norms Regarding Caring

In this category three significant groups of carers were identified as healers, patients and mothers. It is interesting to note that patients are regarded by indigenous healers as carers. The idea of self-care by patients is thus held by healers.

Bommayabotsetsi appeared four times. This is due to the cultural practice of engaging the services of a voluntary family means to look after mother and baby for the first three months after birth. The theme also appears in Domain Number 7: Folk and Professional Health-illness Cultural Systems (see Table 18).

Caring Values

Significant care activities occurring under this them are: looking after the patient, taking patients to either a healer, a clinic or to hospital, administering treatment and referring patients to another healer, clinic or hospital. Enforcing isolation measures and compliance to treatment occurred less than five times. Since the theme is considered insignificant in terms of the number of responses it is nevertheless important in terms of the prevention of diseases.

Domain Number 3: Cultural Taboos and Myths

Data relating to cultural taboos and myths are categorised under proscribed acts and thoughts to avoid actual or potential harm to one’s self or others. Information obtained explains what people believe in and why they behave as they do. Themes have been classified according to specific life events, namely: religious values, menstrual period, pregnancy, labour and mourning period. Table 10 shows beliefs and values relating to taboos.

Neglect of proscribed acts is taboo and refers to omission or commission of certain acts which may result in ill-health.
### Table 10: Beliefs and Values Relating to Taboos

<table>
<thead>
<tr>
<th>Proscribed Acts</th>
<th>Themes</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Failure to inform one’s ancestors (go se bege)</td>
<td>1. Neglect of cultural rites and ceremonies</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Neglect of social norms and values</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3. Care during high risk periods</td>
<td></td>
</tr>
<tr>
<td>2. Failure to sacrifice for one’s ancestors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Go tseneia botsetsi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Failure to be treated when widowed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Having sex with a woman who is “not well”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Go tlodisa ngwana methala</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Failure to put on black clothes after the death of a spouse (go se apare rou)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Improper disposal of sanitary pads</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| N-10                                                       |                                                  |           |

Beliefs and Values Relating to Taboos

The following themes relating to values and taboos were identified.

**Neglect of cultural rites and ceremonies**

The theme occurred in all responses. Neglect of cultural rites and ceremonies such as the slaughtering for ancestors was considered taboo. Such neglect could bring about ancestral anger and diseases.

**Neglect of social norms and values**

The theme appeared in all responses and is considered significant. Failures to put on widow’s weeds and failure to be treated after the death of a partner is taboo and brings about boswagadi. Failure of the last born in the family to wear a cultural bead after the death of one of the parents is taboo and is likely to cause sleeping sickness.

---

20 Rou.
21 Bolokwane.
Care during high risk periods

The theme appears five times and is considered significant. High risk periods in this context are periods during menstruation, pregnancy and labour and the period after delivery of a baby. Care during these periods includes proper disposal of sanitary pads, restricted movement and taking medication during pregnancy, taking medications at the beginning of labour and enforcing isolation measures after labour.

Domain Number 4: World View and Ethnocentric Tendencies

Data on world view and ethnocentric tendencies assist in assessing the informants' knowledge and perceptions of the world in relation to certain phenomena. In this study the phenomena assessed are the overview of the informants' view of health, illness, care providers and receivers of health care. The themes in each category have been identified as reflected in Table 11.

Views on Health

From the data in Table 10 health seems to be viewed in terms of being free from disease and bewitchment, physical and mental fitness, the ability to work and the observing of cultural health rites and rituals. This view of health is also related to Domain Number 3, Beliefs and Values Relating to Taboos.

Views of illness

Illnesses are viewed in relation to their causes. Natural causes, witchcraft and madness are significant causes. Culture-bound syndromes are the second significant causes of illness. Illness caused by an ancestral call for one to become a healer is considered insignificant since it occurred four times but is regarded as important.

Views of care givers

Indigenous healers considered themselves to be care givers. Mothers were considered the second significant group in providing care. Other groups mentioned were family members, bommayabotsetsi and faith healers. Mothers, family members and bommayabotsetsi appear in Domain Number 2: Norms, Values and Behaviour Regarding Caring.

---

22 Ditanyane.
23 Kgaba and makgabenyana.
24 Metlhala and boswagadi.
25 Badimo.
26 Voluntary maternity helpers.
## Table 11: People’s World Views and Ethnocentric Tendencies

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 People’s view of health</td>
<td>1. Non-interference by witches in life</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Harmonious relationships with one’s ancestors</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3. Absence of disease</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>4. Physical and mental fitness</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>5. Ability to work</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>6. Cultural rites and rituals</td>
<td>5</td>
</tr>
<tr>
<td>4.2 People’s view of illness</td>
<td>1. Illness caused by witchcraft</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2. Illness caused by the ancestors</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>3. Dangerous tracks</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>4. <em>Boswagadi</em></td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>5. Natural diseases</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>6. Madness</td>
<td>9</td>
</tr>
<tr>
<td>4.3 People’s view of those who give care</td>
<td>1. Indigenous healers</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Mothers</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>3. Family members</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4. <em>Mmyabotsetsi</em></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>5. Faith healers</td>
<td>1</td>
</tr>
<tr>
<td>4.4 People’s view of those who receive health care</td>
<td>1. Those identified as ill by family members</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2. People visiting healers for divination and treatment</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3. Those who go to hospital</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>4. Those taken to <em>diagelong</em></td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>5. Those who go to healers for sex and fertility problems</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>6. Those who go to healers for disease prevention and health promotion</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>7. Those who go to healers when pregnant</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>8. Those who need to prevent specific socio-cultural diseases</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>9. Those who go to healers for love potions</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>10. Those who need to prevent witchcraft</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>11. Those with culture-bound syndromes, eg <em>thwasa</em></td>
<td>4</td>
</tr>
</tbody>
</table>

N=10

**Views on Those Who Receive Care**

People who visit indigenous healers for purposes of preventing diseases and promoting health, those with sex and fertility problems, those who need prevention against witchcraft and specific socio-cultural conditions are indicated as significant people receiving care. These groups are followed by those who are identified as “ill” by family members and those who go to hospitals. Four informants mentioned those who...
are taken to *diagelong* are people who receive care. Those who suffer from culture-bound syndromes appeared four times and those who visit healers during pregnancy and the possible implications of healer attendance and abnormalities during pregnancy appeared three times and are considered insignificant. In view of the importance of maternal and child care during pregnancy and the frequent encounters with the presence of *thwasa* initiates in the community the last two insignificant themes are considered important.

**Domain Number 5: Cultural Diversities, Similarities and Variations**

Information in this category relates to the general features informants perceived as differences from or similarities to other cultures within their environments. It relates to cross-cultural comparisons of health and illness behaviour, comparing the informants’ views to a second culture and identifying reasons for the differences.

*Table 12: Cultural Diversities, Similarities and Variations*

<table>
<thead>
<tr>
<th>Assessment Domain</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.0 Cultural diversities, similarities and variations</td>
<td>5.1 Cross-cultural comparisons of health-illness behaviour and health care systems (that is comparing the client’s view to a second culture)</td>
</tr>
<tr>
<td></td>
<td>5.2 Reasons for preferring one health care system over another</td>
</tr>
</tbody>
</table>

Data regarding cultural diversities, similarities and variations were obtained from the verbal responses of informants and were confined to formal and indigenous health care systems. Identified themes were used only in terms of these health care systems. Themes relating to the combined use of formal health systems and indigenous healing systems, and the reasons for preference of either indigenous or formal health care have also been identified. Themes identified in each category appear in Table 13.

*Table 13: Domain Number 5: Categories, Themes and Responses*

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Simultaneous use of both systems</td>
<td>1. Use of both systems</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Referral to hospital</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3. Hospitals and clinics</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>4. Injections</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>5. Nurses</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>6. European doctors</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>7. Vaccinations</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>8. Allergies</td>
<td>1</td>
</tr>
</tbody>
</table>

N-10

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*A Hospital belonging to an indigenous healer.*

---

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Chapter 4 — Analysis of Data: p.71
Simultaneous Use of Both Systems

Utilization by patients of both systems of health care was identified in all ten responses. Referral of patients to clinics and hospitals was mentioned by all informants. All informants mentioned treating patients that had, at one stage or another, visited the hospital or clinic. One respondent mentioned that these were “patients which the hospital could not do anything for”.

Use of Formal Health Services

Hospitals, clinics, injections, nurses and European doctors are themes that occurred more than four times and are considered significant.

Nurses and “European” Doctors

This theme appeared eight times. Categories mentioned were considered care-givers by healers. Vaccinations used by these categories in the provision of care were considered effective in the treatment of communicable diseases. Allergies were mentioned as conditions that “European doctors are able to treat successfully”.

Indications from the data are that formal health care services are consulted significantly for purposes of alleviating pain. Operations, although mentioned by less than five informants, were considered important.

Diseases and health conditions taken to indigenous healers for diagnosis and treatment are listed in table 14.

Table 14: Diseases and Health Conditions Taken to Healers

<table>
<thead>
<tr>
<th>Disease or Condition</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phogwana/Tlhogwana</td>
<td>10</td>
</tr>
<tr>
<td>Boswagadi</td>
<td>9</td>
</tr>
<tr>
<td>Impotence</td>
<td>8</td>
</tr>
<tr>
<td>Infertility</td>
<td>10</td>
</tr>
<tr>
<td>Mental illness</td>
<td>5</td>
</tr>
<tr>
<td>Cancer (not cured in hospital)</td>
<td>2</td>
</tr>
<tr>
<td>Fortifying and cleansing homes</td>
<td>8</td>
</tr>
<tr>
<td>Witchcraft</td>
<td>8</td>
</tr>
<tr>
<td>Menstrual problems:</td>
<td>3</td>
</tr>
<tr>
<td>1. Irregular</td>
<td></td>
</tr>
<tr>
<td>2. Excessive</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>5</td>
</tr>
</tbody>
</table>

N=10

All responses showed that diarrhoea and vomiting in children caused by phogwana/tlhogwana is taken to indigenous healers for both diagnosis and treatment. Information in Table 14 also indicates that widows and widowers, people having fertility problems, mental illness, epilepsy and impotence go to indigenous healers for treatment. It is also shown that healers are consulted for family preventive measures against witchcraft.
Patients with cancer and who went to the hospital and could not be cured and those with menstrual irregularities also go to healers for treatment. Responses relating to the cancer theme is insignificant but important in view of the fact that currently cancer has no cure.

Domain Number 6: Life Caring Rituals and Rites of Passage

Categories relating to life caring rituals and rites of passage are listed in Table 15.

Table 15: Life Caring Rituals and Rites of Passage

<table>
<thead>
<tr>
<th>Assessment Domain</th>
<th>Category</th>
<th>6. Life caring rituals and rites of passage</th>
<th>6.1 Rites of passage related to achieving different status or positions in a culture</th>
<th>6.2 Ritual ceremonies in relation to health and illness</th>
<th>6.3 Purpose served by these rituals/ceremonies and rites of passage</th>
</tr>
</thead>
</table>

Data on life caring rituals and rites of passage were identified during interviews. Data on this subject also appears in Domain Number 1: Individual or Group Patterns of Life-style. Categories identified were rites of passage related to different status or positions in a given culture, ritual ceremonies related to health and illness and the purposes served by the ritual ceremonies.

Table 16: Categories, Themes and Responses

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 Rites of passage (achieving a different status in a given culture)</td>
<td>1. <em>Thwasa</em> (initiation to become a qualified indigenous healer)</td>
<td>4</td>
</tr>
<tr>
<td>6.2 Rituals and ceremonies in relation to health and illness</td>
<td>1. Slaughtering sacrificial animal offering</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>2. Cleansing persons of diseases</td>
<td>5</td>
</tr>
<tr>
<td>6.3 Purposed served by ritual ceremonies and rites of passage</td>
<td>1. Creation of harmonious relationships with and prevention of diseases caused by displeasures of the ancestors.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>2. Promotion of health</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>3. Treatment of <em>thwasa</em> symptoms</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>4. Prevention of mental illness</td>
<td>1</td>
</tr>
</tbody>
</table>

Rites of Passage: Achieving A Different Status in A Given Culture

Four informants mentioned the calling by ancestors. *Thwasa* was named as such a calling. It was also mentioned as observed under Domain Number 1, Patterns of Life Style: Sickness Behaviour and under
Domain Number 4: World View and Ethnocentric Tendencies. Since the theme was mentioned by four informants it should only be mentioned, but since thwasa affects the health status of the individual it will be discussed in the next chapter. Informants stated that not going through thwasa could result in mental illness and that the only means of curing thwasa symptoms is to become an initiate and go through the rite.

Rituals and Ceremonies in Relation to Health and Illness

Statements relating to ancestors, practices which relate to rituals and ceremonies were made by five informants. Informing the ancestors and giving an offering for them and giving an offering for them are themes that occurred less than five times but are nevertheless important since they appear in Domain Number 3, Cultural Taboos and Myths as stated beliefs about what could cause potential harm to one’s self.

Purpose Served by Ritual Ceremonies and Rites of Passage

The purpose for the performance of ritual ceremonies and rites of passage was indicated by five informants. Promotion of health and prevention of diseases which could be brought about by ancestral wrath occurred five times. Although prevention of mental illness was mentioned once, maintenance of harmonious relationships in Domain Number 1 entails prevention of mental illness and promotion of mental well-being.

Domain Number 7: Folk and Professional Health-illness Cultural Systems

The domain refers to local and indigenous ways of providing health care to the local people and the roles of local curers and carers. The term “professional health-illness cultural system” refers to the formal system of health care. Folk and professional health-illness cultural systems appear in Table 17.

<table>
<thead>
<tr>
<th>Assessment Domain</th>
<th>Categories (Types of Categories)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Folk and professional health-illness cultural systems and categories</td>
<td>7.1 Folk (indigenous) healers and carers</td>
</tr>
<tr>
<td></td>
<td>7.2 Professional health care healers</td>
</tr>
<tr>
<td></td>
<td>7.3 Diagnosis by folk (indigenous) healers and methods used in diagnosis</td>
</tr>
<tr>
<td></td>
<td>7.4 Treatment methods used by folk (indigenous) healers</td>
</tr>
<tr>
<td></td>
<td>7.5 Treatment methods used by professional healers</td>
</tr>
<tr>
<td></td>
<td>7.6 Treatment methods used by faith healers</td>
</tr>
<tr>
<td></td>
<td>7.7 Benefits of indigenous caring and curing systems</td>
</tr>
</tbody>
</table>

28Go ha begela.  
29Go phasa/go phatlha.  
30Go ha tlhabela.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 4 — Analysis of Data: p.74
Data relating to indigenous (folk) and professional health-illness cultural systems was obtained from statements made by the informants. The statements were grouped as types of indigenous healers and carers, types of professional healers, diagnosis made by indigenous healers and the methods used for diagnosis, treatment of methods used by both indigenous and professional healers and the reasons for the use of indigenous health-illness cultural systems. Table 18 shows the themes identified under each category.

Table 18: Domain Number 7: Categories, Themes and Responses

<table>
<thead>
<tr>
<th>Category</th>
<th>Themes</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.1 Types of folk (indigenous) healers and carers</td>
<td>1. Bone throwers</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>2. Bone throwers and herbalists</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>3. Faith healers</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4. Mothers</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>5. Neighbours</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>6. Bommayabotsetsi</td>
<td>1</td>
</tr>
<tr>
<td>7.2 Professional health care healers</td>
<td>1. Nurses</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Medical doctors</td>
<td>10</td>
</tr>
<tr>
<td>7.3 Diagnosis by folk healers</td>
<td>Types of Diagnoses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Children's diseases</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. General diseases</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3. Gynaecological conditions and fertility problems</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>4. Sexual problems</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>5. Sexually-transmitted diseases</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>6. Culture-bound syndromes</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>7. Family health problems</td>
<td>5</td>
</tr>
<tr>
<td>7.4 Treatment methods used by folk (indigenous) healers</td>
<td>1. Herbal medicines</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Tswana herbs (unspecified)</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>3. Skin applications</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>4. Inhalations</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>5. Scarification</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>6. Enema</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>7. Induced vomiting</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>8. Cleansing</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>9. Massage</td>
<td>5</td>
</tr>
</tbody>
</table>

N=10

Diagnoses made by indigenous healers

Themes identified in this category related to diseases and health conditions found in children, adult male and female diseases, and or health conditions specific to males and females as well as diseases or conditions relating to families. Information in this category does not only relate to diagnosis of diseases and health problems but to treatment of the diagnosed diseases or health problems as well. The following tables show the diseases and conditions diagnosed and treated by indigenous healers according to the different categories. Table 19 shows the diseases of children that are diagnosed and treated by indigenous healers.
Table 19: Diagnosed and Treated Diseases of Children

<table>
<thead>
<tr>
<th>Disease/Health Condition</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teething Problems</td>
<td></td>
</tr>
<tr>
<td>Tlhogwana/Phogwana</td>
<td></td>
</tr>
<tr>
<td>Kokamo</td>
<td>31</td>
</tr>
<tr>
<td>Ditsikana</td>
<td>32</td>
</tr>
<tr>
<td>Makgome</td>
<td>33</td>
</tr>
<tr>
<td>Mepitla</td>
<td>34</td>
</tr>
<tr>
<td>Borathane</td>
<td>35</td>
</tr>
<tr>
<td>Magetla</td>
<td>36</td>
</tr>
<tr>
<td>Kokwana</td>
<td>37</td>
</tr>
</tbody>
</table>

N=10

Gynaecological diseases and problems diagnosed by indigenous healers are listed in Table 20.

Table 20: Diagnosed Gynaecological Diseases/problems

<table>
<thead>
<tr>
<th>Disease/problem</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility (in both males and females)</td>
<td>10</td>
</tr>
<tr>
<td>Irregular menstruation</td>
<td>2</td>
</tr>
<tr>
<td>Repeated abortions</td>
<td>2</td>
</tr>
<tr>
<td>Displaced uterus</td>
<td>2</td>
</tr>
<tr>
<td>Gonorrhea (&quot;drop&quot; in males)</td>
<td>1</td>
</tr>
<tr>
<td>Hydrocele</td>
<td>-</td>
</tr>
</tbody>
</table>

N=10

Information from Table 20 shows that infertility in females is the major problem that indigenous healers are faced with.

Sexual problems relating to males and females were also identified in Table 21.

Table 21: Diagnosed Sexual Problems

<table>
<thead>
<tr>
<th>Sexual Problem</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impotence</td>
<td>8</td>
</tr>
</tbody>
</table>

31 A noun derived from the Setswana word *okama* meaning "being above".
32 Meaning "cramps and colic".
33 Severe skin rash.
34 Tracks.
35 A noun derived from the word *rathela* which means becoming pregnant before the other child is ready to be weaned off the breast.
36 Shoulders.
37 A disease of children characterised by the inability of the anal sphincter to close and delayed walking.
38 *Mokabi*. 

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 4 — Analysis of Data: p.76
The list in Table 21 shows that sexually-transmitted diseases and impotence are the two major problems with which healers are faced. It is interesting to note that two of the respondents referred to boswagadi as AIDS.

General diseases that are diagnosed were also identified from the data. A list of these appears in Table 22.

### Table 22: General Diseases Diagnosed and Treated by Healers

<table>
<thead>
<tr>
<th>Disease</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness</td>
<td>5</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>4</td>
</tr>
<tr>
<td>Skin rashes</td>
<td>3</td>
</tr>
<tr>
<td>Malignant tumours</td>
<td>3</td>
</tr>
<tr>
<td>Sejeso 41</td>
<td>3</td>
</tr>
<tr>
<td>Asthma</td>
<td>2</td>
</tr>
<tr>
<td>Dysentery</td>
<td>2</td>
</tr>
<tr>
<td>Incontinence</td>
<td>2</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>1</td>
</tr>
<tr>
<td>Fainting</td>
<td>1</td>
</tr>
<tr>
<td>Stroke</td>
<td>1</td>
</tr>
<tr>
<td>Snake-bite</td>
<td>1</td>
</tr>
</tbody>
</table>

From the information in Table 22 mental illness seems to be the main disease that is taken to indigenous healers for treatment.

38 Disease believed to be caused by having sexual intercourse with either a menstruating woman or a recently widowed person.  
39 Widowhood.  
41 A poisonous substance that has been eaten.
Information relating to the diagnosis and treatment of family health problems was also identified in Table 23.

Table 23: Diagnosed Family Health Problems

<table>
<thead>
<tr>
<th>Problem</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family disputes</td>
<td>8</td>
</tr>
<tr>
<td>Witchcraft</td>
<td>8</td>
</tr>
<tr>
<td>Presence of tokolosi</td>
<td>3</td>
</tr>
<tr>
<td>Lightning</td>
<td>3</td>
</tr>
</tbody>
</table>

N=10

Table 23 shows that indigenous healers are consulted on family disputes and matters of witchcraft. Although the presence of familiars such as tokolosi and lightning had insignificant responses they are within the area of witchcraft and are considered significant.

Culture-bound Syndromes

Badimo was diagnosed by informants and appears four times. The condition was attributed to calls by the ancestors to become healers and the training process through which the initiate must go was identified as thwasa.

Professional Health Healers

Professional health workers were mentioned by all informants as people who provide care and are significant in that they also appear in Domain Number 5, Cultural Diversities, Similarities and Variations. Nurses and European doctors were mentioned as health care professionals to whom patients were referred either in the clinic or hospital. The mentioning of professional health workers as healers seems to indicate the acceptance by indigenous healers of the relevance of practitioners in the two health systems working together as a team.

Diagnosis Made by Healers

Data showed that a number of indigenous healers first diagnose the problems presented to them before prescribing treatment. Information on diagnosis is categorised into the following groups:

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42Familiars.
Children's diseases: All informants mentioned the diagnosis of teething problems. Phogwana/tlhogwana appeared nine times in the data and kokamo occurred five times. These are considered significant in view of the fact that both conditions are present with diarrhoea and vomiting, a condition that has proved to be a major cause of death in children in developing countries (Kibel & Wagstaff, 1995:233). With the exception of magetla,43 other diseases such as cramps and colic44 although mentioned less than five times are common to specific communities and deserve special attention.

Kokamo and makgome were found to be synonymous and will be used interchangeably. The condition was explained as follows:

Culturally a Motswana widow/widower must be treated to prevent other people from being infected by her. If this is not done such people carry with them some infection and if they touch a child45 the child gets sick.46 Such people leave infectious tracks behind wherever they go so that children who cross wherever widows/widowers have passes become sick as a result of their tracks.47 Sometimes makgome or seroma is contacted by a child from the mother during pregnancy and is characterised by severe skin rash which oozes a watery fluid.

Some children are given preventive treatment before they come into contact with other children. If such children come into contact with children who have not received preventive treatment the latter contact kokamo. In other words those who received preventive treatment become “heavier than” those who did not so that those who did not receive such treatment get sick. Such a treated child is put under isolation for a specified number of days before being exposed to other children.

Gynaecological Diseases and Fertility Problems

The diagnosis of infertility appeared ten times. Other gynaecological conditions such as irregular menstruation, repeated abortions and gonorrhoea, although mentioned less than five times are significant in that they are common problems. Gonorrhoea is significant in view of its sexual nature of transmission as well as its ability to spread quickly.

Diagnosis of Sexual Problems

Impotence occurred eight times. Its diagnosis is important in that it indicates first the sexual health problem with which males are faced and secondly the task healers are faced with as sex therapists.

The diagnosis of loss of libido in females is significant although it was mentioned less than five times in that the affected people are less likely to receive any therapy. The diagnosis seems to indicate that healers

---

43 A condition wherein the shoulders of a child are pulled backwards.
44 Ditsikana and khujwana.
45 Ge ba mo kgoma.
46 Makgome.
47 Metlhala.
are faced with sex problems affecting both males and females. It is also an indication that both sexes seek assistance from the same source of health care.

**Family Health Problems**

The diagnosis of witchcraft and family disputes occurred more than five times (eight times). The diagnosis of the presence of *tokolosi* in the home occurred less than five times but is considered significant since it falls within the witchcraft category. The significance of the diagnosis of witchcraft lies in its occurrence in Domain Number 3: Cultural Taboos and Myths as well as in Domain Number 6: Life Caring Rituals and Rites of Passage.

**Culture-bound Syndromes**

*Boswagadi, khutlego, kokamo, makgoma, metlhala, kokwana, badimo/thewasa* and bewitchment as well as the presence of familiars (*tokolosi*) are culture-bound syndromes since they have no equivalence in western culture. The diagnosis of mental illness occurred five times. Epilepsy occurred four times.

**Treatment methods used by indigenous healers**

Data showed that all indigenous healers have their own methods of treating diseases. Unspecified indigenous Setswana medicine, herbal medicines, skin applications, inhalations, scarification, enema, emetics, massage and cleansing are methods that occurred more than five times. Most of the routes of administration are similar to those used in formal health care services. Informants mentioned that patients are sometimes taken to *diagelong* to be nursed there until they are ready for discharge.

**Prevention of Diseases and Promotion of Health**

Leininger's assessment domains include prevention of diseases and promotion of health as health maintenance behaviour. Data from informants showed the involvement of indigenous healers in the prevention of diseases and the promotion of health. The following are areas in which indigenous healers are involved in preventing diseases and promoting health.

**Prevention of Children's Diseases**

*Phogwana/ihogwana* and *kokamo/metlhala* appeared ten times in all responses. Informants indicated that it is cultural that a child be taken to the healer, or that a healer be called to come and prevent *phogwana* in a newborn baby. Information from the informants show that diarrhoea and vomiting are the manifestations of the disease and that it is the cause that is treated to prevent the disease. One informant stated, "*Phogwana is preventable. Once there is diarrhoea and vomiting, we are late in preventing it*".
Kokamometlala was indicated as another preventable disease in children. One informant stated, “We use legetla so that this newborn baby can be like other babies outside and not be affected by metlala. We let it inhale legetla, and we simultaneously prevent tlhogwana.”

Preventable Adult Conditions

Boswagadi is a culture-bound, sexually transmitted but preventable disease. More than five informants mentioned that a widow or widower must be prevented from contracting the disease by being treated immediately after the burial of the spouse.

Repeated abortions and miscarriages were reported to be preventable by two informants. In Setswana culture one must literally go through a hole in the stomach of a slaughtered sheep thus receiving treatment for prevention of further abortions or miscarriages. Although this aspect of prevention occurred only twice it is considered important in that childlessness among black families could be a source of distress and sometimes cause the breakdown of a marriage.

Family Preventive Health Practices

Measures taken for preventive purposes in the family appear in Table 24.

Table 24: Family Preventive Measures

<table>
<thead>
<tr>
<th>Preventive Measure</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Putting pegs around the home</td>
<td>9</td>
</tr>
<tr>
<td>Prevention of witchcraft</td>
<td>8</td>
</tr>
<tr>
<td>Fortifying the body</td>
<td>4</td>
</tr>
<tr>
<td>Preventing lightning</td>
<td>3</td>
</tr>
<tr>
<td>Preventing divorce</td>
<td>3</td>
</tr>
<tr>
<td>Cleansing cattle and cattle posts</td>
<td>3</td>
</tr>
<tr>
<td>Ensuring that people get jobs</td>
<td>2</td>
</tr>
<tr>
<td>Ensuring the growth of the unborn child</td>
<td>2</td>
</tr>
</tbody>
</table>

N=10

Putting pegs around the home, prevention of witchcraft, fortifying the body, preventing lightning and cleansing cattle and cattle posts are dealt with together since they all revolve around prevention of witchcraft.

---

Go thaya motse.
Treatment Methods Used by Professional Health Workers

Injection, vaccinations and operations were mentioned as methods used by nurses and medical practitioners. Mention was also made of the use of “steels that are put in the ears” or stethoscopes.

Treatment Methods Used by Faith Healers

Since faith healers fell outside the criteria for inclusion in this study no data is available on them and their treatment methods.

Benefits of Indigenous Healing and Caring

The reasons for preference of indigenous healing over formal health services were mentioned by informants. These reasons were also regarded as the benefits of indigenous healing systems. The reasons for preference were stated in comparison to those of the formal health care system and are listed below.

- Indigenous healing is cultural and indigenous healers provide acceptable cultural care. One respondent said, “European medicine has no cultural meaning for us because it is not ours”.
- Indigenous healers tell the client the cause of the problem through their diagnostic methods of divination. The client does not tell the doctor about the problem. European doctors cannot detect the problem without finding out from the patient.
- Indigenous medicine aims at curing and healing. European medicine suppresses the disease.
- Indigenous medicine prevents, treats and cures African culture-bound syndromes. Culture-bound syndromes are unknown to European doctors.
- There are diseases for which European medicine has no treatment or cure, eg repeated miscarriages.
- Indigenous healers protect families against witchcraft attacks. European doctors know nothing about this type of prevention.

There were statements that formal health workers are unable to treat certain diseases successfully and the treatment they provide only suppresses the symptoms. These statements seem to suggest that treatment provided by formal health care workers is only palliative. Three informants explained it as follows: ya bona kalafi e a okobatsa. This literally means their treatment suppresses the symptoms of the disease.

Diseases that seem to be effectively treated by indigenous healers are boshwagadi, khutlego, phogwana and mental health. Informants stated that epilepsy is effective treated if the patient has not sustained a burn.

Informants also mentioned diseases that are best treated by formal health practitioners. These were listed as airborne diseases, operations and communicable diseases of childhood. Immunization by vaccination was mentioned as the best preventive measure of communicable diseases. This seems to indicate

Their treatment only suppresses.
the acceptance of the success of immunization against communicable diseases in children. It also indicates acceptance of their own shortcomings.

There seems to be a relationship between themes on people’s view of health and illness in Domain Number 4, World View and Ethnocentric Tendencies and Domain Number 7, Folk and Professional Health-Illness Cultural Systems.

Domain Number 8: Specific Caring Behaviours and Nursing Care Values, Beliefs and Practices

Table 25: Specific Caring Behaviours and Nursing Care Values, Beliefs and Practices

<table>
<thead>
<tr>
<th>Assessment Domain</th>
<th>Categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific caring behaviours and nursing values, beliefs and practices</td>
<td>8.1 Types of support systems</td>
</tr>
<tr>
<td></td>
<td>8.2 Activities carried out by support systems</td>
</tr>
</tbody>
</table>

Data on specific behaviours relating to care, values, beliefs and practices were obtained from the verbal responses of informants with specific reference to the types of support systems and activities carried out by these systems. Themes identified under each category appear in Table 26.

Health Support Systems

Mothers and family members were significant components in the support system. Family members appeared to be more culturally supportive. In Domain Number 6 they are the ones involved in slaughtering of sacrificial offerings. They are also present during ritual cleansing as well as in acts of propitiation for the ancestors.

Table 26: Domain Number 8: Categories and Themes

<table>
<thead>
<tr>
<th>Categories</th>
<th>Themes</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.1 Types of support systems</td>
<td>1. Mothers</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>2. Family members</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>3. Bommayabotsetsi</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4. Neighbours</td>
<td>2</td>
</tr>
<tr>
<td>8.2 Activities carried out by support systems</td>
<td>1. Identifying the illness</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>2. Looking after the patient</td>
<td>6</td>
</tr>
</tbody>
</table>

50 These appear in Table 25.
Neighbours were identified as another support system in maternal and child health care after delivery. They are said to assist Bommayaboetsi in performing household chores to ensure full recuperation of the mother from pregnancy and labour. Being a voluntary community maternity helper in maternal and child care services appears to be indigenous to Batswana cultural groups.

*Activities Carried Out by Support Systems*

Responses from informants also included activities carried out by support systems. Identifying illnesses and or health problems, looking after the patient and taking the patient to the indigenous healer, clinic or hospital appeared more than five times and are considered significant. Other activities appearing less than five times in Table 26 are also important as system support activities. These activities are related to the people's view of those who receive care in Domain Number 4. Examples of the statements made include, “If a girl has fallen pregnant, I (the healer) call her, but the parents must bring a sheep with, so that she can go through the hole in its (the sheep’s) stomach”. Parents and or close relatives identify the disease and give advice in relation to whether the patient needs to consult the healer or go to the clinic or hospital.

The activity of looking after the patient relates to the family members and includes all aspects of home care, eg the administration of the indigenous healer’s medicines and or the hospital/clinic. It also entails monitoring the improvement or deterioration of the condition of the patient. This qualifies the healers’ view that family members are care providers.

Activities related to maternal and child health care after birth were also mentioned. These include drawing of water for purposes of bathing the mother and baby, cooking and washing for them and fetching wood from the veld for cooking purposes. These activities are continued until the baby “comes out” of puerperium after three months. The number of responses is insignificant but the nursing care implications are highly significant since they relate to “caring”.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Taking patient to clinic or hospital</td>
</tr>
<tr>
<td>5.</td>
<td>Caring for mother and baby after birth</td>
</tr>
<tr>
<td>6.</td>
<td>Monitoring treatment</td>
</tr>
</tbody>
</table>

N=10
Data related to cultural changes and acculturation regarding health-illness values, beliefs, life-styles and practices were obtained by listening to what informants said. From interview data themes relating to statements made by informants were identified as part of the content of those domains previously presented. The themes have been interpreted as health-illness seeking behaviour, health-illness diagnosis, identification of carers and curers, treatment methods of the formal western system as well as indigenous health systems. Identification of the advantages of both systems and the reasons for preference of one system over the other appears in domain numbers 5 and 7. From the point of view of the informants there is a simultaneous use of both systems with patients commuting between the two systems of health care. The indigenous health care delivery system remains supported by all respondents.

**Analysis of Data From Users of Formal Health Services**

Twelve users of formal health care services were interviewed for purposes of comparing their responses with those of the healers. Questions asked were similar to those put to indigenous healers. The questions covered prevention of diseases and promotion of health in children, adult males and females and families. The primary question posed was: “Explain to me how indigenous healers contribute to health. Responses to this question appear in Table 28.

**Table 28: Users Views of Contributions of Indigenous Healers**

<table>
<thead>
<tr>
<th>Contributions</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. They help (not specified)</td>
<td>12</td>
</tr>
<tr>
<td>2. They diagnose conditions accurately</td>
<td>7</td>
</tr>
<tr>
<td>3. They prevent specific problems/diseases</td>
<td>6</td>
</tr>
<tr>
<td>4. They treat diseases</td>
<td>8</td>
</tr>
<tr>
<td>5. They stay with patients at diagelong</td>
<td>6</td>
</tr>
<tr>
<td>6. They cure diseases</td>
<td>6</td>
</tr>
<tr>
<td>7. They look after people</td>
<td>4</td>
</tr>
</tbody>
</table>

N=12
The general impression is that healers offer help in most care situations. This was mentioned by all respondents although the kind of help offered was not specified. Prevention of specific diseases and health-related problems, staying with the patient at the hospital of indigenous healers, diagnosing and treating diseases as well as curing them were significant themes.


Information relating to prevention of diseases in children was also identified and appears in Table 29.

Table 29: Users’ Views of Diseases of Children Prevented by Indigenous Healers

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tlhogwana/Phogwana</td>
<td>8</td>
</tr>
<tr>
<td>Dikgaba</td>
<td>9</td>
</tr>
<tr>
<td>Diarrhoeal diseases</td>
<td>6</td>
</tr>
<tr>
<td>Khujwana</td>
<td>4</td>
</tr>
<tr>
<td>Ill-health from maternal death</td>
<td>4</td>
</tr>
</tbody>
</table>

With the exception of dikgaba and ill-health due to maternal death, tlhogwana, khujwana and diarrhoeal diseases appear in Domain Number 7, Folk and Professional Health-illness Cultural Systems. They also appear under “Prevention of Children’s Diseases”.

The information gathered from users seems to support that of indigenous healer informants. It is noted that tlhogwana and diarrhoeal diseases are similar in that the former has the same clinical symptoms and present with diarrhoea and vomiting. Dikgaba is a culture-bound syndrome in that there is no English equivalent to it and its treatment is avuncular in nature.

In six sessions shoes were removed. Information relating to disease and health-related adult conditions that are preventable was also identified. These appear in Table 30.

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[^51]: Abdominal colic.

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SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 4 — Analysis of Data: p.86
Table 30: Users' Views on Preventable Adult Diseases and Conditions

<table>
<thead>
<tr>
<th>Disease/Condition</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness</td>
<td>11</td>
</tr>
<tr>
<td>Boswagadi</td>
<td>8</td>
</tr>
<tr>
<td>Unwanted pregnancy</td>
<td>8</td>
</tr>
<tr>
<td>Hydrocele</td>
<td>6</td>
</tr>
<tr>
<td>Mogato/Kokamo</td>
<td>4</td>
</tr>
</tbody>
</table>

N=12

Mental illness, boswagadi, unwanted pregnancy and hydrocele ranked high on the list of preventable diseases among adults. Unwanted pregnancy, although not a disease, is considered a social disease and therefore is considered important. Boswagadi and kokamo/mogato appear in Domain Number 7, Folk and Professional Health-illness Cultural Systems. Prevention of mental illness appears in Domain Number 6, Life Caring Rituals and Rites of Passage, as well as in Domain Number 7. It is noted that mogato/kokamo appears under diseases of children. It is also interesting to note that it appears to be transmitted to children by untreated adult widows and widowers.

Information relating to family health preventive measures was also identified and presented in Table 31.

Table 31: Users' Views of Situations Against Which Family Preventive Measures are Taken

<table>
<thead>
<tr>
<th>Aspect Prevented</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witchcraft</td>
<td>8</td>
</tr>
<tr>
<td>Familiars, eg toko/osi</td>
<td>8</td>
</tr>
<tr>
<td>Theft of corpses</td>
<td>4</td>
</tr>
<tr>
<td>Spoiling weddings</td>
<td>4</td>
</tr>
</tbody>
</table>

N=12

Prevention of witchcraft, of which the presence of familiars is part, appear in Domain Number 2: Non-interference by Witchcraft in One’s Life. There is a belief among the Batswana that witches are capable of exhuming a corpse and spoiling people’s jovial ceremonies; that this also is an aspect of witchcraft.

Data from users suggests that diseases of children as listed in Table 32 are successfully treated by indigenous healers.
Table 32: Users’ Views of Diseases Successfully Treated by Indigenous Healers

<table>
<thead>
<tr>
<th>Disease</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tlhogwana(^{52})</td>
<td>8</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>6</td>
</tr>
<tr>
<td>Dikgaba</td>
<td>6</td>
</tr>
<tr>
<td>Ditnatanyane</td>
<td>4</td>
</tr>
<tr>
<td>Infertility</td>
<td>12</td>
</tr>
<tr>
<td>Makgome/Boswagadi</td>
<td>10</td>
</tr>
<tr>
<td>Mental illness</td>
<td>9</td>
</tr>
<tr>
<td>Hydrocele</td>
<td>8</td>
</tr>
<tr>
<td>Impotence</td>
<td>8</td>
</tr>
<tr>
<td>Sexually transmitted diseases (drop)</td>
<td>6</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>2</td>
</tr>
<tr>
<td>Adultery in men</td>
<td>1</td>
</tr>
<tr>
<td>Gangrene</td>
<td>1</td>
</tr>
</tbody>
</table>

N=12

Infertility, impotence, mental illness, makgome, sexually transmitted diseases and high blood pressure appear in Domain Number 7. Although high blood pressure and adultery in men appeared less than five times they are considered important.

Treatment of homes by healers was mentioned once and rehabilitation of the mentally ill was also mentioned once.

Field Observations

Field observations were undertaken in order to obtain accurate information about health constructs. Indigenous healers were observed in their natural working environments within which activities took place. Activities were identified and grouped into themes. Information on observed patterns of life-style appear in Domain Number 1.

Healers were asked to have a divination session with the researcher before the scheduled interview. The purpose of the session was first to ensure transparency on the part of the researcher and to build a

\(^{52}\)Tlhogwana, Diarrhoea, Dikgaba and Ditnatanyane are all diseases found in children. Tlhogwana appears in Domain Number 7; ditnatanyane appears in Domain Number 2 as a preventive measure used against ditnatanyane or the failure to thrive. Ditanyane is the medicine used to treat and or prevent the disease ditantayane. There appears to be symbolic relationship between the disease and what is used for its treatment or prevention.
relationship of trust as well as to establish rapport between the healers and the researcher. The second reason was for the researcher to become a data collecting tool and to obtain inside, first-hand information about the activities performed by indigenous healers. This aspect of data collection was considered important in view of the little information available about the health care activities of indigenous healers.

**Health Screening**

**Divination Methods**

All healers were asked to have a divination session with the researcher before an interview was conducted. Eight of the ten healers threw bones. One combined bone throwing with *mankgonyana*. One used tea leaves to divine and one used the *Bible*. Figure 4 shows bones used for divination.

**Figure 4: Bones Used for Divination**
Divination Rules

There were rules to be observed by clients and patients. In six sessions shoes were removed before entering the divination hut. The structure of the huts seemed important for their purpose. Five of the huts were found without windows. In one incidence the hut was big and the light subdued, but dark inside. The shape and the hue seemed to be important in indigenous treatment of certain mental illnesses. The huts were used by the Sangoma type of healer. In all huts observed there were round-shaped with no windows. Figure 5 shows a typical Setswana reed hut for divination purposes. The interior of the healer’s consulting and dispensary rooms was noted. This included observation of the standard of environmental hygiene. Pounded medicines were packed neatly on shelves. Hides, horns and snake skins hung from the roof. Twigs and barks of trees as well as roots were neatly put away (See Figure 6). The wives were observed to play an

Figure 5: Typical Setswana Divination Hut
important role in the environmental cleanliness when the healer was a male. A wooden as well as steel mortar and pestle were used for pounding purposes.

In all eight bone-throwing sessions the client sits either on a sheep or goat skin, or a mat made of reeds, with all shoes off or with only one shoe off. In all sessions the feet and legs were extended. On the door one hut was written, “Menstruating women must not enter this room. Inform the doctor if you are ‘ill’”.

![Image of Interior of a Healer’s Dispensary](image)

**Figure 6: Interior of a Healer’s Dispensary**

**Divination Charges**

An amount is charged at the beginning of the session and the client is told at the beginning to ensure that he/she can afford the fee. In four instances the money was put in the bag containing the bones or under the goat skin on which the bones were thrown. The charges ranged from R5.00 to R20.00. A record book is kept of those who are still to pay. The record indicated whether it is a physical illness or home fortification that is being paid for. The diagnosis is not indicated.

**Assessment and Diagnostic Methods**

**Bone-throwing**

Divining bones are called *bola* or *diatoia* and are kept in a special bag for this purpose. The bag is held onto the mouth of the client to breathe in after which it is emptied onto the goat skin used specifically for the purpose (see Figure 4). In a poetic and praising manner, the healer related the position of the fallen bones in relation to one another. The meaning and relationship of the position of the bones is interpreted to the client. Questions are asked where necessary and the client is asked to agree or disagree as the healer tells
what is seen through the bones. The client does not tell the healer about his or her problem. The healer must identify the problem from the bones and tell the patient.

Mankgonyana

This is a wooden pictorial structure made of wooden sticks joined at certain points. The structure is held and controlled by the hand. The wooden structure is asked questions and it is expected to respond. For instance such a question as, “Where does this client come from?” and the command, “Show me the direction from which the client comes”. The structure is moved to and fro and will face either north, east, west or south depending on the direction from which the client came.

Tea leaves

When using this method the healer prepares tea for the client. No milk is added to the tea. The client drinks the tea but leaves a little of the liquid with the leaves in the cup. The healer is in a position to look and “see” in the cup an divine the client.

There are certain rituals that must be performed in this method of divination. The client takes the cup, closes his/her eyes and concentrate on the problems he/she has brought. The cup is then inverted into the saucer so that the excess tea is poured into the saucer. With his eyes closed the healer then takes the cup and concentrates. The healer looks carefully into the cup as if he/she reads letters written on the sides of the cup. From this manoeuvre problems are identified and a diagnosis is made.

The Bible

Divination takes place in a room where the healer’s herbs are kept. The client sits on a chair with both shoes on. The client is given the Bible to place on the forehead. With eyes closed he/she must then concentrate on his/her problems. With eyes still closed, the book is then placed on his/her chest. With eyes still closed the client is then asked to open the book and hand it to the healer. The healer divines by interpreting what he/she reads from the Bible.

Using these methods of divination and depending on whether or not the client agrees the diagnosis is arrived at. Consultation and questioning takes place throughout the session. The diagnosis is the result of a joint agreement between the two parties with the healer telling and the client confirming. The health care plan is discussed and agreed upon by both the healer and the client. There is participation of the client throughout.

Divination is discussed under the category of sickness-behaviour in Leininger’s culturologic assessment found in Domain Number 1. Observation showed however that those who come for divination sessions were not necessarily ill. Some came due to certain specific concerns about their lives. For instance checking on
important role in the environmental cleanliness when the healer was a male. A wooden as well as steel mortar and pestle were used for pounding purposes.

In all eight bone-throwing sessions the client sits either on a sheep or goat skin, or a mat made of reeds, with all shoes off or with only one shoe off. In all sessions the feet and legs were extended. On the door one hut was written, “Menstruating women must not enter this room. Inform the doctor if you are ‘ill’”.

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Assessment and Diagnostic Methods

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Health Maintenance

All ten informants went to fortify homes. Observations were that a healer first divines the place to determine any witchcraft-related problems and to find out what could be done and how best it could be done. The house and the yard are done first. Members of the household are cleansed. Pegs are then planted at each corner of the yard, at the gate, main entrances and at all corners of the house. Finally a herbal medicine is burnt in the house so that the smoke fills all rooms. The household members are fortified by scarification.

Treatment

Persons are cleansed before they are fortified. Fortification could take the form of inhaling burnt herbs while patients are tucked under blankets, scarification with a razor blade and the application of herbs on bleeding incised areas. In all five incidents of scarification observed patient brought their own razor blades. Patients were instructed to destroy the blades by breaking and throwing them away.

Enema and induced vomiting using emetics were observed in five instances. The treatment method appears to be used often due to the belief that it will remove swallowed poison or that if the poison is allowed to rot it will come out as faecal matter.

Medications are either administered by indigenous healers themselves, those apprenticed to assist them or one of the children showing an interest in indigenous medicine. More often than not the patient or a family member is given instructions on how to administer the medications. Observation confirms what Conco (1972:285) and Pitje (1971:6) mentioned, namely that ordinary traditional medications can be administered by anybody with some empirical knowledge of medicinal plants.

Ritual cleansing was observed in three different instances. In all situations a sacrificial chicken was used, each of a different colour for each patient. On each occasion the offering was made to drink a herb-solution before slaughtering. In each case snuff was used by both the healer and the patient. In each case there was talking to the ancestors with the patient requesting the ancestors to remove the disease. Blood was used to cleanse the patients; this was followed by a medicinal bath. In each instance the patient, once washed, was not allowed to look back. The chicken was garnished with medicine and roasted on an open fire after which the patient was instructed to eat the roasted chicken. Certain parts (drum ticks) were eaten by the healer and the researcher. Finally the researcher was sprinkled with the same medicine and asked to leave with the patient and told to never look back until they reached home. Ancestors therefore form part of the therapy and talking to them assists one to verbalize pent-up emotions and fears.

\[54^\text{Thayalmapola.}\]
\[55^\text{Speiti.}\]
\[56^\text{Go kapa.}\]
\[57^\text{Sejeso.}\]
one’s life or finding out whether a journey would be uneventful. This observed behaviour was categorised under health maintenance behaviour.

In all ten informant’s homes the names of clients were found and all went through a divination session. This seems to suggest that all clients are expected to go through a divination session to ensure the correct diagnosis of the problem or to agree on it, even if it may not be correct.

**Treatment Methods**

Different treatment methods used were also observed. These included oral medications⁵³, emetics, enema, scarification, cupping, steaming and inhalation. Figure 7 shows the equipment used for administration of an enema. For respiratory problems inhalation therapy is administered by placing medicinal roots in water which is brought to boiling point. A blanket is placed over the patient’s head and the patient is instructed to inhale the steam from the boiling mixture. Gelfand (1964:61) makes mention of this kind of treatment amongst the Mashona. Common colds and flu’s are treated with *lengana, benereiti* and *serokolo*. These are readily available herbs grown at indigenous healers homes. Healers also encourage patients to have medicinal plants in their homes. The risk of burns and scalds from the steam methods of treatments was considered very high in that the patient was not allowed to make any opening from underneath the tugged blanket(s).

**Figure 7: Equipment Used for Administration of an Enema**

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⁵³*Dipitsa.*
presence of the healer and the talking to the ancestors about the problem at hand formed the focus points of the ceremony (see Figure 9).

**Figure 9: Ancestral Veneration Ceremony**

![Image of Ancestral Veneration Ceremony]

**Thwasa Treatment**

Only the song and dance aspect was observed on two occasions. The thwasa initiate goes into and operates under trance. The songs are unique. The dance consists of jumping and stamping hands on the floor. Families and neighbours participate in the song but not in the dance. Drums are played as part of the song and dance.

**Figure 10: Thwasa Initiate Dancing While in Trance**

![Image of Thwasa Initiate Dancing]
Summary

This chapter presented the analysis of data. Terminology related to health care is explained; and Leininger's Culturologic Assessment Domains are used to analyse the data. Chapter 5 discusses the findings of the data analysed in this chapter.
CHAPTER 5
Discussion of Findings

(it) relies at local levels, on health workers, including physicians and nurses ... as well as traditional practitioners as needed, ... to work as a health team and to respond to the needs of the community (WHO, 1975:5)

Introduction

In Chapter 5 an analysis of data collected from three different samples was presented. This chapter presents a discussion of the findings of the data previously analysed.

Cultural Health Care Terminology

Cultural terms and phrases consonant with the provision of health care were consistently used. These included go thaya motse, 1 go tlhapisa, 2 moparego, 3 go nwa dipitsa, 4 go sa bone thari 5 and go tswa ka soba la mogodu. 6 These terms and phrases are value-laden in relation to the provision of health care and their meaning is important for the successful provision of a relevant and acceptable health care delivery service. The use of cultural language in the provision of health care is what enhances the acceptance of the health care system by virtue of being understood by the users. The fact that the language used by indigenous healers is the same as that used by users opens the healers health care prescriptions to total acceptance due to the existing common understanding of terms used. The use of acceptable and meaningful language is vital to the provision of all health services.

The above paragraph suggests that when the language is not indigenous to the user of the health service compliance with health care directives relating to medical prescriptions could be low. This finding also points to the importance of knowing and adapting the language used locally to health care situations in order to facilitate better understanding of health care terms to the users of the same cultural groups. Language used by formal health workers and healers in a particular locality should convey the same message and meaning to users. The differences in health and medical terminology causes communication breakdown and confusion and brings about disruptions in the health care process due to a lack of understanding of health messages. The findings also underscores the importance of using local health terminology to clearly convey health education messages, especially if the educational level of users from lesser-advantaged communities is taken into consideration. The use of western medical terms in the provision of health services for black

1 Putting medicinal pegs around the homestead for purposes of fortifying it against witchcraft.
2 To cleanse a home, including the occupants, or cleanse individuals.
3 Room accommodating mother and new born child.
4 To drink (usually) boiled oral medicine.
5 A term used to describe a woman as being unable to have children or as being barren.
6 Literally means “treatment”.

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SN Shii-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Chapter 5 — Discussion of Findings : p.98
people with little or no knowledge of such terms is defeating the objectives of primary health care since for the latter to be effective care must be provided in the language that is understood. In providing health services the healers are in better positions to be understood by those they serve. It is the understanding of the terms and phrases used in the language utilized for providing health services that all health workers should strive for in order to provide an effective health service to the South African population.

The use of euphemisms attached to conditions that undermine an individual’s self-esteem is within itself therapeutic. The use of blunt language as found in formal health services is insulting and offensive to Africans. Calling a spade a spade is not cultural to certain cultural groups and could be perceived as “vulgar”. The perception could result in patients avoiding formal health services. This “respectable” way of presenting health conditions could be maintained. However, in the situation of life and death and where life takes priority over death a spade needs to be called a spade in order to save life.

The use of cultural terms is important in describing culture-bound syndromes for which western medicine has no names. Unless syndromes such as thwasa and go tswa ka soba la mogodu are mentioned in cultural terms they are likely to lose the meaning and treatment may shift from cultural to foreign western models which have failed to cure them (Mabetoa, 1992:61; Karlson and Moloatoa, 1984:27).

For instance dipitsa has been explained as boiled oral medication usually a mixture of more than one herb. While the action of the different herbs could enhance one another positively the possibility of the chemical compounds of different herbs causing toxicity cannot be overlooked, especially since no chemical analysis or toxicity test is performed prior to any administration. The problem is compounded by the fact that there is no precise measurement for the amount of herbs used. This could have fatal results. On the other hand dipitsa have been used since the black person was born and experience seems to have taught the healers how much herbs to use in each situation. Except for isolated incidences identified by hospital medical practitioners there is no statistical evidence to convince one that the dipitsa as used by healers are dangerous; however there is enough evidence that these herbs heal (Gumede, 1990:69; Mutwa, 1974:79; Chavunduka, 1972:8). If this was not the case Swantz’s question is pertinent: “... why do some 800 to 10,000 clients visit them every day, when government services are offered free of charge?” (Swantz and Swantz, 1975:311).

The names of certain diseases indicate the healers’ insight into the behaviour of diseases. The association of the behaviour of a mole with the metastatic behaviour of a malignant tumour is indicative of the healers’ knowledge of how certain diseases behave. It is logical to give the disease the cultural name characterising its behaviour without necessarily calling it cancer. The characteristic nature and use of the

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7Moon rising is the literal meaning; but in this usage it refers to a person “called” to become a healer.
8Means, literally, “going through a hole in the stomach”.
9Senmya
10Serunya

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Chapter 5 — Discussion of Findings : p.99
indigenous names of diseases such as serunya is important in the educational training of health care sessions since it facilitates indigenous understanding of the behaviour of diseases such as malignant tumours.

*Go thaya motse*\(^{11}\) is basic and important to every black family. Culturally no black person can erect a house without calling an indigenous healer to come and thaya\(^{12}\). The belief in witchcraft is the compelling motive in wanting to prevent any unwanted family happening from people with evil intentions. It becomes imperative that a clean household have muti\(^{13}\) pegs planted around it to prevent witches and familiars from entering the household. It is the preventive meaning that is important. *Go thaya* literally means to lay a trap. It makes sense therefore that if one believes that intruders can come into a house laying a trap to catch them becomes the solution.

The idea of infection is understood but in cultural terms. The term methala\(^{14}\) denotes infection that is acquired by moving from one place to another. Whether such “tracks” are of people or animals is immaterial. What is important to understand is that for fear of contacting methala\(^{15}\) the movement of certain high-risk people from one place to another is prohibited. Understanding the meanings of these terms thus enables the community health worker to understand, for instance, why many mothers of newborns do not attend their first post-natal care clinics usually scheduled for six weeks after delivery.

The Batswana of the Northwest Province use the cultural *go sa bone thari* indicating the “inability to bear” or that something is barren and unable to reproduce. This term is also indicative of the cultural aspects attached to certain conditions that create negative feelings and attitudes amongst the people. Lack of knowledge by health care workers of the proper idiomatic expression to use during conversation or physical examination resulting in the blunt use of words could discourage rather than encourage people to utilize formal health services.

In this study therefore the use of appropriate language by health workers for communication purposes is considered to be of major importance. The users of indigenous health services are also users of formal health services and when they visit clinics and hospitals the only language they understand is their own. This is also the language used by indigenous African healers. One cannot expect indigenous users of formal health services to begin to learn western medical terminology simply because one needs to be attended to by a community health worker. It is important however for community health workers to understand the cultural meanings of indigenous conceptions of health and the idiomatic expressions used by patients to express these conceptions in order to facilitate the provision of appropriate care in both the indigenous and formal health care systems.

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\(^{11}\)Fortifying a homestead.

\(^{12}\)Literally means to lay a trap.

\(^{13}\)Preventive medicinal pegs.

\(^{14}\)Means “tracks”.

\(^{15}\)Diseases left behind by the tracks of people and animals.
Health Beliefs

Beliefs relating to health centred around protection from witchcraft, prevention of infection and material and child health care after child birth have been briefly discussed in the preceding paragraphs. While the theory behind witchcraft could be considered by westerners to be utter nonsense, it should be emphasized here that beliefs in witchcraft are real among South African blacks and should be viewed not only as a theory but also in practical terms also. If all healer respondents and all formal health users interviewed agree that witchcraft exists, then it exists. If experiences of “familiars” such as tokolosi are expressed as being real by the people, then there is a need to see witchcraft from their points of reality.

The findings of this study show that indigenous healers are in a position to deal effectively with health issues relating to witchcraft. This means that non-indigenous health care delivery systems fail to deal effectually with such health matters. There is therefore some technical medical expertise known only to indigenous healers. It is this expertise and knowledge that should be tapped in order to save communities from the blight of witchcraft. Closing ones’ eyes to the reality of the types of health problems confronting indigenous African populations does not and will never contribute to the delivery of effective health to the people. If witchcraft is only a belief the techniques used by indigenous healers to alleviate those fears and the pain accompanying the belief need to be exploited and used for health and healing purposes.

Critical analysis clearly indicates that positive indigenous health practices occur because of beliefs in witchcraft. The findings of this study show that sensible personal hygiene and sanitation are practised to offset possibilities of being bewitched. Young girls are educated about good environmental health norms at an early age, and teenage girls are encouraged to ensure conception by maintaining high standards of personal hygiene, especially the proper disposal of sanitary pads lest the soiled pads be stolen by a witch. Pregnant mothers are expected to stay at home during the latter months of their pregnancy; and for reasons of health these combined aspects are important. If a pregnant woman is to avoid complications during labour, her belief in witchcraft is a positive one in terms of rest and sleep for delivery of a healthy child, and for her own health following delivery. The fear of being bewitched during pregnancy however spills over into puerperium and can be considered to be unhealthy since mothers of new-borns are not allowed to walk around outside the homestead from immediately after delivery for as long as three months. This practice leads to lack of exercise and overweight. It also prohibits mothers from attending post-natal clinics at six weeks which is a critical period for checking whether important healing processes have occurred in a normal manner. There is thus the predisposition to missing an early detection of cervical cancer.

There is also a statement that malignant tumours occur due to witchcraft and are treatable and curable. This accounts for the loss of some cancer patients from formal health care systems to the services of indigenous healers. It is the curative aspect that should receive emphasis not witchcraft. Until proper scientific research is undertaken the possibility of the statement being true cannot be completely dismissed.
There is an avuncular relationship that health exists among the Batswana. Treatment by concerned relatives becomes the means for the attainment of social harmony and health. When a sick child is treated by an uncle or an aunt the healing activity results in the establishment or strengthening of already existing positive relationships. In addition to physical healing and health this activity brings about the healing of social relations since relatives are compelled to communicate with one another in order to solve particular health problems. This activity seems to reinforce the idea that health is also a state of social well-being. Barke (1973: 81) supports this finding by mentioning the strong avuncular-nepotic relationship existing among blacks and the role of an uncle in the prevention of diseases.

Sejeso as a health problem is real among South African blacks; and to think that people do not perceive it as a threat to life would be unrealistic. The diagnosis of any life threatening health problem is likely to receive immediate treatment that is considered appropriate. It is however the treatment modalities of sejeso which cause concern. Induced herbal vomiting and the administration of herbal enemas are the two main treatment methods used to remove the poison from the alimentary tract. While it is rational thinking that any swallowed element could be removed by vomiting or through the faeces it would seem that indigenous healers are not aware that poisons are absorbed into the blood stream and may not remain localized in the digestive system. Unless the treatment is aimed at neutralizing the poison already absorbed in the body fluids treatment may not be effective. Also, physical assessment of the condition of the patient is important. In the event a patient has lost a lot of fluid or weight and urea and electrolytes have not been ascertained, subjecting the patient to further fluid loss through vomiting could prove disastrous.

If not looked after and kept clean the equipment used for the administration of an enema can cause disease. Figure 7 shows that the catheter and tubing are connected with a cloth. First, there is no lubrication on the tip of the used catheter. This lends the rectal mucous membrane to abrasion and damage. The cloth used for connecting the catheter and the tubing is inappropriate and is not changed for the next patient; and herein lies the danger of spreading infection from one person to another. In this era of AIDS the administration of enema by healers is considered a dangerous practice for as long as their administration procedures remain unchanged.

Patterns of Life Styles of Individuals or Cultural Groups

In this study it was shown that patterns of life-style significantly influence the health behaviour of individuals or groups. People consult healers for purposes of divination either because they are ill, have problems of an ancestral nature or they want to know about their future or business prospects. The fact that indigenous healers are consulted to determine what could happen during the course of the day, or whether a journey will be eventful or not, indicates their involvement in the prevention of accidents and untoward

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16 Internal poisoning.
happenings. Expressions such as: *ge di ka gana, di a kgomela-a-madiba, ga go a siama*\(^\text{17}\) and *go tswetswe* emphasize the ability of divination techniques to “see” into the future and to facilitate the initiation of the planning process relating to the problem at hand. This approach is emphasized by all planners within any viable health care delivery systems.

That healers consult with people who have already been to the hospital or clinic shows that the mere diagnosis of a disease by hospital or clinic personnel is not enough. Seeking confirmation of the real cause of the health problem from the healer indicates the importance of trust in the healer about knowledge of diseases; even if some causes could be incorrect. It also underscores the importance of utilizing the two systems of health care to ensure that health checks and balances are maintained; and since the formal health care system could not ensure that this is done, the people themselves have introduced their own system of checks and balances. This shows that people do not have to be dictated to about their health needs and the manner in which they are to go about solving them. What is needed is for people with expert knowledge to meet the health needs. Whether the disease/health problem will be taken to the healer or formal health practitioner depends on each case. The held perception of the meaning of the disease, the seriousness of the illness, the availability of the particular health service and the financial position as well as the person who makes the decision are determinant factors. People in both rural and urban settings may choose to consult an indigenous healer in what they perceive as less serious diseases and later turn to formal health services. They will also try the latter and if a cure is not forthcoming soon enough they will turn to the healer. Ghavunda (1976:1) states that others play it safe by consulting both services at the same time. People need all the health assistance they can get and there seems to be no contradiction in attending a sacrificial ritual at 6h00 and go to church at 11h00. As du Toit puts it, “It all comes down to multiple treatment for multiple causes” (du Toit, 1980:45).

The findings of the study show that the health care activities of healers are governed by written ethical codes of conduct (see Annexure 1) as well as rules, even though the latter may not be written. Contrary to what might have been perceived as disorganized practices of witchcraft, the study shows that indigenous healers are professionals in their own field of practice, governed by a relevant ethical code of conduct. This suggests the existence of elements of policy formulation and control in carrying out their health care activities. It also suggests the existence of a structural way of operation, however basic.

The existence of records of attendance and of financial payment indicates the level of awareness of record keeping. This is critical in the provision of health services since the users are then on record. Since recorded information was found to be inadequate it is of even greater importance that all the diagnoses and treatments given be recorded. This move would facilitate referral in cases of need. It would also enable

\(^{17}\) If the divination bones refuse, it is no good. It means the road is closed. Proceeding with the journey may result in an accident; thus the journey is cancelled.
locating the healer in cases of death from herbal toxicity or overdoses. Such records could further be used in the certification of deaths so that the cause of death could be specifically identified. At present existing records are elementary, but important for further improvement of the service.

Access and availability are related to the amount of money one is able to pay. The amount paid for divination is considered affordable only if the charge is no more than R10.00. If it is more the additional amount paid for treat appears to negate the idea that the services provided by indigenous healers are financially affordable unless payment is in both cash and/or kind. Depending on what is treated, indigenous health services could be just as expensive as, if not more than, the formal health services. If the treatment is of a minor ailment the charges will be low, but if household prevention measures are taken, a minimum of as much as R800.00 is required. This amount of money may not be afforded by some of the rural communities served by indigenous healers. Since the service is considered important the amount is acceptable and the service continues to enjoy the support of the people.

Health Maintenance Behaviour

To a black being healthy is being free of disease and accidents. Consultation with indigenous healers for purposes of divination serves as confirmation of the presence or observation of disease or the possibility of the occurrence of accidents through means of witchcraft. For this reason a divination session is important in determining the events of the day including whether a trip will be successful. If it is revealed through divination (screening) that the trip is likely to be an eventful one it is cancelled or postponed. This indicated the importance of determining the health aspects of a journey and the value of divining before embarking on it to ensure that one remains in good health. Nothing can be more preventive than avoiding an accident!

The behaviour of consulting a healer by blacks for purposes of wanting to know the future is also stated by Forsen (1982:239). The fact that the service can be provided immediately but also allows for the patient to pay later makes the service instantly available. Payment in cash or kind enables the patient to pay with whatever means he/she can. This aspect makes the services of indigenous healers readily available and affordable in terms of screening and accessibility because they are always on call in the community where the people live. Affordability of the service is relative and depends on the type of disease or health problem, and where the service is needed.

Disease and Health Promotion

The findings show that fortification is at the heart of the prevention of diseases in persons. All healers mentioned fortification and all users of formal health services mentioned that indigenous healers “help”18

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18"Help" in the context of indigenous healing is an inclusive term which includes the fortification of persons

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Chapter 5 — Discussion of Findings : p.104
people. Ten incidents of fortification were observed. Fortification is thus extended from homesteads to people so that they are not vulnerable to witchcraft.

The fact that a cleansing ritual takes place before fortification ensures removal of diseases that might be in the body prior to fortification. Therefore it is not surprising that induced vomiting is practised to remove any swallowed poison or that medicinal enemas are administered to cleanse the lower bowel of any poisonous elements which might possibly be present. The idea behind cleansing is to free people of the potential for witchcraft related diseases.

While scarification, a practice currently in use, is active its negative aspects cannot go unnoticed, since scarification as a method of fortification could be dangerous. The spread of communicable diseases such as AIDS is likely to occur unless precautions are taken. In this study it was observed that patients brought their own razor blades to the healer. Disposal of the blade involved breaking it into two pieces before throwing it away. One could not be sure whether or not every patient brought a razor blade or whether in all cases the razor blades were thrown away. There was no indication from the healer of him/her having knowledge of any simple technology relating to sterilizing the razor blade such as burning its edge in the flame of a spirit lamp. The probability exists that those patients not in possession of razor blades could be incised with ones that were previously used. In the absence of clear indications of proper disposal or sterilization procedures the possibility of the spread of blood-born infections exists. Since there is no control relating to where the used razor blades are thrown children could find the blades and use them; and this within itself constitutes another health risk. The criticism that substances used by healers are not standardized in accordance with scientific criteria and that the instruments used could transmit disease (Blacket-Sliep, 1989:44) could be valid. In unleashing this criticism however one should not lose sight of the fact that even in the sterile conditions of the hospital iatrogenic diseases do occur. It should not appear as if infectious injuries result only from the side of indigenous healers.

Nutrition

The value of eating proper foods in preventing diseases was mentioned by five healers and was also instrumental in a portion of the treatment of certain diseases. For instance salt and milk are contra-indicated in asthmatic patients until the patients are completely healed. Although the rationale behind such a contra-indication was not mentioned there are people who are allergic to milk protein, in which case the prohibition of the eating of these food products would be valid. Cancer patients are not allowed to eat red meat. This finding is supported by western medicine through research into the causes and prevention of cancer. Indigenous healers allow patients to each chicken but ingesting the skin and fat is prohibited. However,
whether or not these dietary restrictions are scientifically valid is not the issue; the issue is the promotion and maintenance of good health. The skin of the chicken is fatty and fat is unhealthy. This message is not only proclaimed by all indigenous healers; health fanatics are also no exception to the same prohibition. Both seems to preach the same message of avoiding foods with high cholesterol content.

Sickness Behaviour

Health screening

Indigenous healers see divination as central to health screening. All ten indigenous healers interviewed used different forms of divination techniques. The final product of screening in all ten instances was the diagnosis of a health problem. It is argued in this study that indigenous healers do not just guess that a health problem exists. They have their own ways of assessing the presence of a problem be it with tea leaves, bones, the Bible or mankgonyana. The taking of case histories occurs simultaneously with divination and the patient or client is given an opportunity to agree or disagree with what the divination technique reveals. Unlike formal health services diagnosis of the problem is a joint agreement between the healer and the patient/client. Confirmation of the diagnosis, cause or the existence of a health problem should be considered in terms of the benefits of the indigenous health care system. Consultations with healers take place because there are benefits, be they cultural, social, or health related. One of the benefits shown in this study is that of "being told" about the problem. Unlike formal health care workers the healer "tells" the patient or client the problem. The ability to state a problem without the patient mentioning such a problem has been considered therapeutic (Harding, 1975:437; Ruiz & Langrod, 1976:96). The ability to divine and tell the health problem puts the healer in a better position of trust than that of the formal health care worker. This could be the reason why patients go to the healer after consulting formal health workers; and since patients tell their problems to formal health workers the latter may not be convincing enough that in actual fact they know what the problem is. Diagnosis could be based on guess work. The person-to-person approach, the agreement on the health issues at hand as well as the rapport and communication established between the two are important determinants of whether or not the patient/client honours the payment of the outstanding fee and/or returns for treatment. This relationship based on trust is found lacking in formal health services. The fact that healers are consulted for purposes of divination to determine health status underscores the expertise of healers in health screening techniques. The ability of the healer to discern the presence of a health problem is as important as the performance of a urine test by the formal health care worker. The emphasis is on the results of the divination. Divination techniques are thus powerful health assessment tools not available within the present formal health care system. This type of local

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21 A human toy-like, joined wooden structure controlled by hand and used for divination.

22 Go itlhathoba.
technology is readily available and needs to be fully exploited. More so, telling people about their existing problems seems to be satisfactory to users, especially when compared to the current questioning approach used in history taking by hospital and clinical personnel. If it works for the patient or client and they are satisfied then it works! If it did not work clients and patients would discontinue asking for divination sessions with healers.

Treatment

In this study treatment was found to be primarily directed at the source of the health problem determined in the divination session. The findings also showed that patients who come to indigenous healers for treatment first went to consult the formal health workers and were not satisfied with the treatment results. A comment from three healer informants that “Europeans do not treat to heal the disease; they only suppress it”, seems to be relevant. If this statement is not true Swantz & Swantz’s (1975:311) question is then relevant: “Why do some 800 to 10,000 clients visit them every day, when government services are offered free of charge?” It confirmed in this study that those patients who “drop out” of the formal health system “drop into” the services of indigenous healers. There is something very satisfying about the treatment offered by indigenous healers that blacks find lacking in the formal health services.

Good relations between the living and the ancestors

The existing relationship between persons and their ancestors determines the sickness behaviour of individuals. If it is diagnosed that ill health is due to ancestor displeasure then the climate of that relationship has to be put right. The behaviour of the patient is the result of indigenous religious beliefs that Modimo (The Great Spirit) cannot be approached directly and that no rituals can be directed to Modimo (Farrand, 1980:89; Devilliers, 1985:398). There has to be a mediator(s) who will plead on the person’s or the peoples’ behalf. This is a matter of tradition in the same way that — according to African tradition — one does not speak directly to the king, but through an intermediary. It is the same with illness. Through divination the assistance of the ancestors is invoked to mediate with Modimo on behalf of the living relatives. Five cleansing rituals and five sacrificial offering ceremonies were observed by the researcher and in all instances the client(s) called upon the ancestors to intervene on their behalf.

Rituals are by their very nature religious activities. One would not expect a South African black to mould his/her life style on the European/western model; nor can a European/Westerner use his/her religion as a yard stick for measuring African religious practices. du Toit (1980:21) correctly states that in many instances Christian converts are expected to “somehow forget their traditional religion and ... to place all their faith in medical science while turning from practices that proved beneficial to their mothers and fathers. We tend to forget that a person cannot be ‘born again’ in toto when a new basis for belief is accepted or

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Chapter 5 — Discussion of Findings: p.107
when faith is placed in new curing properties.” If the argument is that people must change then it is also correct to argue that change in one behavioural sphere does not necessarily bring about change in every other sphere of thought and action. Also the motivations for change in one area might not apply to the areas of belief and behaviour. While South African blacks attend formal health services for certain illnesses the use of indigenous healers is not necessarily replaced by such attendance. In addition the users of the services of indigenous healers might remain active members of Christian churches. Membership does not erase those aspects in which the ancestors and rituals continue to be of importance to them. The fact is emphasized by the statement that healing has very clear religious basis and overtones and that these are enhanced by rituals (du Toit, 1980:22).

The power of the spoken word during communications with the ancestors is a characteristic feature in traditional African medicine and cannot be undermined. In the same way that church-goers communicate verbally with their God healers instruct their clients to talk to their ancestors, to tell them their problems and put needed requests before them. The fact that the healer does not speak on the client’s behalf means that healers are merely mediators in the performance of rituals and ceremonies. It is the patient/client who earnestly speaks to and asks his/her ancestor — o bua le badimo — for assistance; it is this earnest communication with some supernatural being(s) which constitutes prayer and serves as the basis for the forming of the relationship between the living and their ancestors. This communication then becomes that of Africans praying to his/her Modimo through the Ancestors. There is a lot of talking and sometimes crying in this kind of communication. It is the cathartic nature of the talk that is therapeutic in that repressed emotions are verbalized. Speaking is a powerful tool and its power is supported by Horton (1967:157). This is what is done in other religious spheres. People speak to their God(s); and sometimes to plants as well. Credo Mutwa relates that he went to America only to discover that “it was the ‘in thing’ for film stars and other American people to talk to their house plants; a thing known to Africans many years ago. I don’t understand why in South Africa the witch doctor is being put in the cold while the rest of the world is proving this value” (Gumede, 1991:127). In this respect Koumare asks:

Might not ‘incantations’ which are mere words, inducing sound waves, have some effect likely to induce endogenous secretions and influence the biosynthesis of substances produced by plants? (Koumare, 1983:26).

Cultural Values Regarding Health Care

All ten healers and all twelve users of formal health care services expressed the value of indigenous healing. Expressions such as: “It is Setswana cultural treatment” and “It is our culture” indicate that to blacks indigenous health care systems are value-added. Whether a person consults a formal medical health practitioner matters not; for in the final analysis an indigenous healer will be consulted provided the health

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needs of that person are not satisfied. If the cause is not acceptable in the mind of the patient the service of
the indigenous healer is likely to be sought. The approach used by formal health practitioners which still
emphasizes the disease and not the person who is ill is directly at variance with the approach used by
indigenous healers in the treatment and care of patients. Many authors view the health model of explaining
the health needs of blacks as attractive due to a multiplicity of factors found within their cultural world views
et al (1987:36) views this factor as an indicator that the ministrations of indigenous healers are consonant
with the cultural beliefs of the people. It is this cultural compatibility that makes the services of healers
relevant and acceptable.

Prevention of Diseases and Promotion of Health

Findings have shown the involvement of indigenous healers in the prevention of diseases and promotion
of health from the cultural perspective. The diversity of the cultural groups found within South Africa must
be considered, especially that for care to be effectively utilized it should be seen to be culturally acceptable.
One cannot perceive prevention only in terms of immunization campaigns by formal health care workers.
There are such cultural means of immunization by healers as well specifically for the prevention of certain
diseases especially those of children. When people speak of go soutisa, they mean “to immunize”. These
are expressions that indicate insight into preventable diseases. Qualitative expressions have been made that
when the child starts to have diarrhoea and vomiting “we are late with preventive measures”. Expressions
such as this serve to indicate the seriousness with which prevention is regarded especially that in child health
diarrhoea and vomiting are regarded as the number one killers of children in the world. If indigenous healers
prevent some of the world’s fatal paediatric diseases there is cause to consider them seriously and to include
them fully in health teams regardless of where they are functioning. The primary focus is that they can
prevent certain diseases. If primary health care means providing measures that will prevent the occurrence
of disease and promote health at grassroots levels where people live then indigenous healers are reputable
primary health care providers. Black mothers know that after birth children must be taken to the healer for
prevention of diarrhoea and vomiting or phogwana. In this respect indigenous healers are specialists in
preventive health care of children; they are the people who put the ideology of the rights of the child to good
health into practice.

Prevention of diseases and promotion of health within the context of cultural beliefs and values relating
to taboos must also be considered. Omission or commission of certain acts could bring about illness and it
becomes imperative that taboos be observed. The performance of rituals and offerings for the ancestors, or
failure to be treated when widowed, may not be dismissed simply as nonsense. The neglect of social norms

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Chapter 5 — Discussion of Findings : p.109
could lead to social disintegration and unless communities uphold their values there may not be a way of preventing social diseases.

In view of the fact that the family forms the fabric of any community extension of preventive measures into the areas of family and social health is regarded as vital. During this era of family disorganization and social instability the healers' ability to prevent divorces and to enhance love and peace within the family is vital in bringing about social order and stability. Any chaos within the family will have a ripple effect on the society. Since, other than the church, there is no mechanism put in place to ensure family stability the healers' strategies are timely and could save families from disintegration. This is so because the churches do not seem to succeed in containing family and social health-related problems.

Aspects of health mentioned by all healers and all users of formal health services and covered the following five areas:

- family preventive measures;
- prevention of diseases in children;
- preventive measures directed at individuals;
- preventive treatment during widowhood; and
- prevention of repeated abortions or miscarriages.

The findings of this study show that indigenous healers function as independent family health practitioners. Preventive measures are directed first at the family. Schapera (1979:60) views this preventive measure in the case of a chief’s kraal as “the conservation of a capital”. This means that the family is regarded as the nucleus of health without which individual health will not be achieved. The fortification of the yard and the bonding of the husband and wife in their new dwelling place “to ensure lasting marriage and to prevent divorce” bear witness to the healer’s commitment to family health and stability. The information also shows that divorces and separations are not permissible in African culture and it is the healer’s role to ensure that its devastating effects do not destroy the health of families. Hence husband and wife are jointly “worked at” together with the land on which they intend to construct a home. The move is also important in ensuring that the children born to the family are not bewitched, are prevented from attack by lightening or familiars such as tokolosi, and to ensure that the couple engages in constructive work. One informant puts it clearly: “The Europeans put security fences around their homes. We fortify our homes. It is our security”. Wealth among blacks is measured in terms of the number of cattle they own and since these can be the source of envy, cattle posts are treated like homes in order to prevent them from being struck by lightening and other forms of witchcraft. This is a preventative measure aimed at the

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24 An invisible, short, hairy animal believed to be utilized by witches.

25 Poas: a place for rearing cattle away from home.
preservation of property. Since cattle are a source of food and wealth, proper preservation of livestock amounts to prevention of nutritional diseases and maintenance of economic resources.

The findings also show knowledge of the behaviour of genetic disorders among indigenous healers. One respondent stated: "When a boy wants to get married in a family of mentally subnormal people we ask him whether he would like to one day have such children. We discourage him." The discouragement is both a preventive and educational measure relating to mental subnormality and its genetic implications. It shows that contrary to their being regarded as ignorant witch doctors they have an enormous working knowledge and actually carry out educational activities where formal health workers cannot reach the people. Their education and advisory role is confirmed by Ejeckam (1977:2). This educational role should be expanded to their knowledge of medicinal plants and acknowledged.

The value of life and therefore of children is central to most black families; and abortions and miscarriages are prevented in an effort to conserve this value. Prevention of children's diseases is also out of the woman's fear of being divorced if she has no live children. In this instance the fact that both husband and wife submit to preventive measures relating to childhood diseases supports the idea that among black people there is no family without children and that children are regarded as part of one's wealth.

Specific isolation measures are taken to ensure prevention of diseases and maintenance of maternal and child health under the care of indigenous healers. The period after delivery is a critical one in view of the potential for infection of both mother and baby. Putting lepakwana26 at the entrance of the doorway for everyone to see makes more sense to a rural illiterate person than putting up a notice board bearing the word "isolation". Since the community understands the meaning of the stick they will not enter the room. What could be more effective that culturally understood preventive measures? And this is what domiciliary midwives should know and encourage. The use of lepheko27 as a child health preventive measure used by the Bapedi28 of South Africa are also mentioned by Monnig (1967:102). Issues such as prevention of pregnancy and disease and the creation of pleasant social environments are certainly crucial to South Africa. Where illness is attributed to cold, exposure is avoided; where mourning rites are expected meticulous observation of such rites is followed; where people are suspected to have crossed "dangerous tracks"29 and could therefore harm those at risk, lepakwana is placed at the door of the hut accommodating those at risk. According to Foster (1983:22) these examples "are just as much preventive medicine as are immunizations and environmental sanitation" (emphasis added).

It does seem as if indigenous healers are the only health practitioners capable of maintaining social cohesion and stable social relationships through the practice of rituals and ancestor veneration. There also

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26 A stick placed at the entrance of a room or hut as a warning to outsiders that mother and baby are in isolation.
27 Bapedi word meaning the same as lepakwana (see above footnote).
28 Bapedi: a people of South Africa living mostly in the Northern Province.
29 Metlhale.
seems to be some benefit in the sacrificial offerings, be they goats or chickens, and to argue that these are merely cultural superstitions is to wear a purposeful blindfold to the reality of the African health care situation. The psychological implications of religious rituals relating to health care can no longer be ignored. Table 16 shows that rituals were considered as serving a purpose to promoting health. If health care providers preach that health is concerned with physical, psychological, social and spiritual well-being then it should be acknowledged that indigenous healers provide a means of bringing about the psycho-social and spiritual well being of the indigenous black people of South Africa.

Religious beliefs have a great influence on believers. Badimo\(^\text{30}\) is a religious concept that impacts on the whole being of indigenous black Africans. If God is a Spirit, those that dwell with him, the angels, are spirits. To Africans their ancestors (Badimo) are the spirits that are next in line to Modimo the Great Spirit. Since, according to African culture, one does not directly communicate with the King, all communication must of necessity go through the counsellors; and in this case it is the ancestors who are delegated by Modimo to communicate with their living relatives. It then makes sense to regard the ancestors as guardian angles who need to be told of all matters affecting life and death. If this approach to health reduces stress and brings about better social relationships it is in the interest of community health that for the benefit of the users the approach be adopted and practised openly and widely.

### Diagnosis and Treatment of Diseases

The findings show that a variety of diseases and health conditions are taken to indigenous healers for diagnosis and treatment.

#### Diagnosis

It is not only in incidences of disease that people seek diagnoses. Diagnosis is sought in all situations that affect a person’s life. Consultation for purposes of diagnosing the reason for the failure of a business to thrive or to find out whether or not the undertaking of a journey will be eventful are illustrative cases. No disease is involved, but the identification of existing or potential problems is sought and more often than not diagnosed.

In order to arrive at a diagnosis indigenous healers follow a definite procedural pattern. The process is different from that followed by formal health workers during health-screening but some specific steps for assessment were identified. What could be called history-taking emanates from revelation through the use of diagnostic instruments, eg diving bones or tea leaves. This is in contrast to how formal health practitioners ask the patient or take the history from patients. In other words the healer’s role is to diagnose the problem irrespective of the method used for diagnosis, and to communicate that diagnosis to the

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\(^\text{30}\) Those of the Spirit.
patient/client. After the problem is identified by divination an interactive process of questions and answers between the healer and client/patient begins. This is a crucial point in indigenous healing for it is at the diagnostic stage that the trust of the patient is won or lost by the healer. If the result is trust then good rapport is established and the basis for following the prescribed treatment and for subsequent returns is determined. This aspect of diagnosis is different in formal health services and the inability to meet the diagnostic expectations of black patients by formal health workers could be responsible for the dual utilization of both systems of health care. The patient thus makes use of the health service that satisfactorily meets his/her health needs at any one point in time. If he/she is not satisfied with the diagnosis of one, he/she proceeds to the other until his/her needs are satisfied.

Treatment of diseases

It has been indicated somewhere in this study that certain diseases are regarded by both healers and users of health services as European diseases, that is diseases that are considered to be successfully treated by formal health care workers. If some diseases are known to be successfully treated by formal health workers, then there are those that are well-known to be successfully treated by indigenous healers. The users are therefore selective in the conditions and diseases they take to indigenous healers. Those diseases that are considered best treated by indigenous means are taken to indigenous healers. It is therefore the user rather than the healer who determines whether or not the healer’s treatment has been successful in treating a particular condition. If one health system does not work for the user the latter switches over to the other system. There is therefore a continuity of choice by those in search of health care between the two health systems.

The fundamentals of primary health care include, among others, nutrition and education. The findings of this study show the involvement of healers in nutritional health education at the level of consumption as it relates to specific diseases brought to them for treatment and care. Restrictions of fat and salt intake is a familiar phenomenon in hospitals and clinics when dealing with patients suffering from high blood pressure, heart and kidney diseases. This study shows that in addition to these well-known diseases there are others for which restrictions are imperative — diseases which personnel in formal health care services may not be aware of. This calls for even closer cooperation between healers and formal health workers in order to open up avenues for education and discussion on matters affecting community health. Only when all health practitioners of both systems begin to engage in health issues addressing the basic tenets of primary care at peripheral levels can the slogan of “health for all” begin to be meaningful.

The findings show the involvement of healers in the treatment and care of a variety of diseases that were either presented for the first time or were previously treated within the formal health services but were not cured. Tables 19 — 22 show the conditions and diseases of both children and adults that are taken to

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention. Chapter 5 — Discussion of Findings: p.113
treatment modalities of diseases and conditions specific to South African blacks. This fact alone should convince formal health professionals that alone the orthodox methods of health assessment, treatment and care are not sufficient; that a complementary system of health care is needed to deal effectively with problems dealing with the failure of certain aspects of either health care system. A system is needed also to deal with those aspects of failure within the formal western health care delivery system and that will deal successfully with cultural illnesses.

Certain diseases and health care problems are taken to indigenous healers for assessment and treatment due to their cultural nature. It is also in view of how the people see the meaning of the illness. If the perceived meaning is that the illness is not natural the healer will be consulted for assessment, diagnosis, treatment and care. The same is true of an illness that is considered culture-bound. In all circumstances a relevant and acceptable practitioner is needed. This is secondary prevention of chronicity, irrespective of who provides the preventive measure. It is the curative aspect that should receive emphasis.

The treatment of infertility and impotence by healers is crucial since this aspect of health does not seem to be successfully treated within the formal health service. It is acknowledged that within the African context it is unacceptable for a married woman not to bear children. Infertility exposes the woman to ridicule and disgrace. This also applies to males who cannot perform sexually since they are considered inferior to other males. According to the findings these two specific health problems are attended to successfully by healers. This means that no one health care system can be considered superior to the other. The problems are taken to the hospital and when success fails the roots of the healers should be put to work. If the opening of the fallopian tubes could not bring about the desired result seeking successful methods of addressing the problem at hand is the only sensible thing to do. If the healer has the solution to this problem it is to the advantage of the client to be referred to the healer for consultation.

Sexually transmitted diseases other than gonorrhoea and perculiea, to blacks, have been revealed by the findings of this study and have been described as “killer diseases”. This study has shown that these diseases are treatable and curable. It is therefore clear that not all diseases are known. There are some diseases that may not be known due to their cultural nature but that are active in the community due to their sexual nature. Boswagadi could be one such disease; and if it is sexually transmitted it will be difficult to eradicate. There is evidence in this study that it is preventable, treatable and curable. Indigenous healers are in the forefront of primary health care in preventing such diseases and treating them. That only healers have the expertise to deal with social health problems such as boswagadi is a disadvantage to community health. Knowledge of treatment of such diseases should be common to all people within the community to ensure that they are

31 Fallopian tubes are a pair of ducts opening at each end into the uterus and at the other end into the peritoneal cavity over each ovary. They serve as passages through which ova are carried into the uterus and through which spermatozoa move out towards the ovaries.
prevented and/or treated. It is also evident that western medical knowledge is limited. Local diseases are better known and preventable or treatable by local people with knowledge of local health resources that are affordable. Primary health care is available only when people are able to provide their own care from within with resources they themselves can provide without buying or importing from somewhere else.

Mental healing approaches are crucial aspects indicative of the quality of care offered within a given health care situation; and to this end indigenous African healers seem to be effective in the treatment of mental disorders. This finding is supported by Green (1980:499). A study by Shai-Mahoko (1996:30) shows that of the thirty-five healers interviewed 60% mentioned that they were engaged in the treatment of mental illness. Half (50%) of the healers and three-quarters (75%) of the users sampled mentioned this. Other authors (Harding, 1973:201; Lambo, 1973; Ademuwagun, 1974) support these findings. Magoba (1984) concurs by stating that mental illness is better treated by indigenous healers. This finding calls for a review of the treatment for people with mental illness. Instead of taking every patient to a psychiatric hospital patients could be taken to a healer for assessment and treatment, especially since the view of informants is that "Europeans do not treat to heal the disease, they only suppress it". These are specialists in mental health aspects and in view of current social stresses more of the health services should be encouraged. Only violent patients could be taken to hospital for sedation and returned to the healer when they are stabilized. Such an administrative approval would relieve hospitals of the burden of overcrowding, but would necessitate the establishment of strong community psychiatric services.

The value of music and dance in the treatment of diseases cannot be overlooked from the point of view of this study in the treatment of culture-bound syndromes such as thwasa. Music and dance are important in invoking supernatural powers through a trance. It is through song and dance that the affected person is shown what to do and how to go about it in order to be healed of the distressing symptoms. It is also through song and dance that the healer is able to go into a trance and divine. Song thus creates the best medium for the ancestors to act through a person. Song and dance are thus important healing strategies and the healer is at the heart of all healing mechanisms in this situation.

The training of Sangomas seems to be on the increase and Motlana (1988:117-118) regards their existence of training as "the tyranny of superstition". Superstition is a concept that applies only to those whom the phenomenon does not make sense. To the people who understand the meaning behind these occurrences and happenings is not superstition. It is reality; and must be treated as such. Setiloane (1986:29) ascribes such attitudes to the teachings of those who came to civilize the African without first making an attempt to understand the culture of those they came to civilize. In fact some authors feel that these practitioners feel disdain and are competitive and thus give information that is "based on samples of patients who come to them after failure in the hands of the traditional practitioner. While their impressions confirm the incompetence of the indigenous healers, that many of their own patients perceive treatment
confirm the incompetence of the indigenous healers, that many of their own patients perceive treatment failure in their hands and seek out help from the indigenous healers goes unreported" (Imperato, 1974:42). The past inabilities of educators in nursing and medicine to become fully integrated into the cultural components of the African subcontinent, and of South Africa in particular, has led to the neglect of the health service potential of the indigenous African healers in this country; a serious omission correctly interpreted as an act of professional irresponsibility (Holdstock, 1979:118). The arrogance with which western medical professionals regard indigenous healers defeats the whole objective of providing acceptable community health care. Sight should not be lost that these personal attacks on each other tend to make the real issue of keeping and maintaining the health of communities less important and song and dance appear to be one such mechanism. Harding (1975:439) also views music and dance as valuable in the treatment of diseases.

The duty to remain with the patient and his relatives during illness and to provide care, and if the patient dies, to officiate at the rite of passage into the After-life is one of an indigenous healer’s health care activities. Actually this is what caring is all about and except for officiating the rite of passage this part of caring is what most nurses do. Conco (1991:12) states that all health care systems have four main objectives:

- to cure;
- to offer relief as often as possible if the cure has failed — to comfort always;
- for the doctor (the sangoma, inyanga or therapist) to him/herself become treatment by utilizing himself therapeutically; and
- to be available to the patient at all times until the end.

Children’s diseases

Diarrhoea and vomiting in children (phogwana) is the characteristic disease among children. Teething is also characterized by diarrhoea. The indication of the ability of healers to prevent and treat diarrhoea and vomiting in children warrants special attention. An early study by Shai-Mahoko (1996:32) supports the findings of this study: that phogwana is treated by indigenous healers and that the condition is preventable. The statement by one respondent that, “Once diarrhoea and vomiting has set in, we are late”, indicates that healers know the course of this particular type of diarrhoea and vomiting and that preventive measures for such illnesses are often neglected. Every mother in the community should take diarrhoea and vomiting seriously and take measures to prevent it. When referring to formal sector medical care, one respondent states: “The nurses’ drips do not cure phogwana”. This statement suggests that the treatment given in clinics for this condition is directed only at the symptoms; that the oral rehydration taught to the communities is palliative. If the emphasis is on prevention, the cause of the diarrhoea and vomiting must be the target.
With the possibility of recurrence the findings suggest that given timeous prevention *phogwana* may not occur. Given the fact that the disease is a great killer of children (Kibel & Bach, 1989:35; Wagstaff, 1995:233) this finding could be beneficial to child health. Oral rehydration therapy should compliment indigenous preventive treatment. If mothers of children are convinced that the money paid for prevention of this condition is worth the treatment then it must be working. The fact that other childhood diseases were not mentioned could be attributed to the success of immunization campaigns. It means that healers have accepted that communicable diseases of children are now “European” diseases and should be treated by formal health workers. This is positive in that they acknowledge that they do not know the treatment for all diseases.

**Adult diseases and health problems**

The findings of this study show that indigenous African healers are private family practitioners deeply involved in family health practices. One cannot imagine a black family without its own healer practitioner to ensure non-interference by witchcraft and to strengthen the family in such a way that all goes well. Personal medical care is provided to different family members and rituals are performed if and when necessary. Family disputes are taken to the healers; and when love wanes they are consulted. This finding seems to suggest that the healer is a reputable family health practitioner. More importantly, they perform the activities that family practitioners in the formal health services cannot perform. If they prevent divorce and family disputes they are at the centre of family health. This study also suggest that their possible contributions to the reduction of family violence should not be undermined. In this context the healer is the builder of a peaceful nation and the nurturer of botho.32

Findings also show that conditions diagnosed and treated by indigenous healers are gynaecological in nature relating primarily to fertility and sex. Table 20 shows that all indigenous healers are faced with problems of infertility among many married females. This finding suggests that black women want to have babies born within a marriage. It also suggests that abortions that are performed be they by back-street abortionists or legally are not of necessity for women who are married and whose marriages are intact. Moreover childlessness in most black cultures is considered negatively. One is familiar with such terms as “she does not bear” or “she is a mule”. Since formal health care services do not seem to be successful in dealing with the problem of infertility the role played by indigenous healers is that of cementing the matrimonial bond by ensuring that children are born to childless marriages.

Any black man who cannot “perform in bed” is considered by the society to be even more disgraced than a woman who is barren. This of course has negative psychological effects which could worsen his impotence. It is interesting to note that both healers and users mention that healers are good at treating and

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32*Humanity.*
curing this condition. It cannot be argued that impotence is only psychological since it is treated with medicinal herbs. This statement also does not imply that impotence is purely a physical condition. If the healer can apply both their psychological and medicinal skills and address this problem successfully, it should be acknowledged that they are professionals. Also one cannot argue that the herbs are placebos since a mixture of herbal medicines is used for treatment.

The findings also reveal evidence of two sexually-transmitted diseases of a cultural nature. *Khutlego*³³ and *boswagadi*³⁴ were mentioned throughout. Cultural norms dictate that one cannot have sex with a woman or a man immediately following and abortion or widowhood without first being treated for prevention of these diseases. The belief is that whoever engages in sex without proper treatment will immediately die. Resistance to abortion among black people arises partly from the cultural connotations associated with *khutlego* following abortion and suggests that those who have legal abortions should in terms of black culture be treated in order not to infect men. It is questionable whether those within the formal health sector who provide this service to black women are aware of the cultural aspects of abortion which raises the possibilities of resistance within the black population to the new Abortion Act of 1997.

As stated earlier contributions made by indigenous healers in cases of mental illness cannot be ignored. Table 23 shows that half of the indigenous healers interviewed deal with people with mental health problems. A study conducted by Shai-Mahoko (1996:32) showed that of thirty-five healers interviewed 60% mentioned mental illness as a clinical activity in which healers were involved. Other authors (Lambo, 1973:20-23; Ademuwagum, 1971:55) support these findings. Mogoba (1984) through a study to determine if mentally ill black patients are better-treated by indigenous African healers concurs with these findings. It is also worth noting that some hospitalized patients upon release sought the services of indigenous healers rather than returning to formal health care workers for outpatient care. Whether one wants to call indigenous healers psychiatrists or crooks a combination of their therapies seems to work for the mentally ill.

**Similarity in diversity**

The approach of formal health practitioners to health is completely different from that of indigenous African healers. This is partially the result of the differences in orientation to health care and training in the treatment of disease. The similarities as far as the diagnosis and treatment outcomes need to be acknowledged. All care aims at identifying the health problem and solving it. Although there could be

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³³A sexually transmitted disease believed to be caused by having sex with a woman who either has had an abortion or is menstruating.
³⁴A sexually transmitted disease believed to be caused by having sex with a widowed person prior to the prevention of the disease.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Chapter 5 — Discussion of Findings: p.118
While similarities are acknowledged there are also differences. The equipment used in prevention, treatment and care functions by healers could however lead to infection. Except for the use of new razor blades healers do not seem to have any knowledge of sterilization. Instruments such as porcupine quills would be very difficult to sterilize. Personal and environmental hygiene is very low. These are factors that could help spread diseases rather than contain them. Disposal of used blades is not controlled or monitored with the result that children could still use them. This suggests that even home accidents resulting from used equipment are not considered.

Medicinal herbs are kept within reach. Children are exposed to these potent medicines. It does not seem as if healers are aware that like dogs children eat anything and everything. Precautions need to be take against poisoning from easily accessible herbs for children.

However, as mentioned earlier, the negative aspects of prevention of family disputes and witchcraft cannot be overlooked, eg the use of instruments such as razor blades for purposes of scarification enhance the danger of introducing blood-borne infections since the cleanliness and sterility of a healer’s equipment is questionable except if the equipment or instrument is new. The similarity lies in the fact that even in hospitals errors do occur. If it were not so iatrogenic diseases would not exist.

**Family health problems**

Family health is of primary consideration because it is an important segment of a society’s social fabric therefore the diagnostic role of the indigenous healer in the determination and provision of solutions to family disputes is vital. Findings identified that two aspects of family health problems are treated by indigenous healers: family disputes and witchcraft. It is not surprising therefore that indigenous healers are intricately involved in dealing with family health problems. Because the nature of their treatment involves exposure to what happens in the homes of their clients they have the ability to diagnose and stabilize family disputes. Within this context healers can be seen as the builders of a peaceful nation and the nurturers of *ubuntu*. 35

Witchcraft is a major problem amongst South African blacks. It is not only the people of the Northwest Province who are plagued by this problem; and there exists an erroneous belief that only blacks embrace this belief. The findings of this study indicate that other ethnic groups, for instance white people in South Africa go to indigenous healers for the purpose of treatment for witchcraft-related problems. In both samples indigenous healers were seen even by white families as being capable of driving away *tokolosi*. 36 Witchcraft then is not a belief held solely by blacks; and because of the nature of witchcraft itself it is an accepted belief amongst these groups that some people are capable of negative manipulation of natural forces; and that those

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35 *Humanity.*

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who seek the assistance of indigenous healers believe they are capable of dealing with such manipulated forces in ways which cause reversal of these negative process, thus attaining a return to normality.

Culture-bound syndromes

Treatment of specific culture-bound syndromes by indigenous healers is of great importance. These conditions are unknown to western culture but are extant in African societies; and since they are foreign to western models of health care indications are that they cannot be dealt with properly in formal health care sectors. The findings of this study suggest that by virtue of their expert knowledge of and skill in the treatment of culture specific they are able to treat conditions that cannot be treated through western cultural means. The specialization in care by indigenous healers is an important consideration especially for purposes of collaboration between traditional and formal health care workers. It is also important to the provision of proper and effective health care since these are diseases that can easily be incorrectly diagnosed by formal health care personnel.

The findings also show the involvement of healers and significant other people involved in providing health care. The findings also show the specific health care activities undertaken by the care groups. Looking after patients, treating and referring patients to hospital, a clinic or other healers are mentioned. It is interesting that indigenous healers acknowledge their own limitations by referring patients to others, including formal health workers. The health support systems of indigenous healers are highlighted in this study.

Healers themselves recommended that their practices be confined to the community. It is convenient for the performance of rituals and sacrifices in the community. Taboos are better observed in the community and neglect of them could mean trouble. However, cross referral of patients must take place in the direction of both health care systems. If the provisions of the National Health Plan of South Africa (1994) are to take effect the resistance of formal health practitioners, especially medical practitioners and some religious groups, will have to change to accommodate indigenous healers. The one-way referral system to formal health workers by healers undermines the spirit of cooperation and trust between the healer and formal health care workers. It is argued that healers trust formal health care workers but that the latter betray the healers’ trust. Attitudes and beliefs of this nature are at the root of determining whether implementation of the National Health Plan (1994) will be a practical reality; for as long as the one-way referral system is the maintained policy implementation, especially regarding cooperation between the two entities, it is bound to fail; and the National Health Care System of South Africa will not be transformed.

In this study the family was found to be the health support system of choice with mothers and other family members shouldering the caring activities. This finding should alert community health workers to the fact that health is in the hands of the people and care should be left in the hands of these very people.
In this study the family was found to be the health support system of choice with mothers and other family members shouldering the caring activities. This finding should alert community health workers to the fact that health is in the hands of the people and care should be left in the hands of these very people. Formal health workers compound the understaffed care deliver system by taking over the care activities that the communities themselves can take care of. This is either because they do not trust the people or their job positions are threatened and they want to secure those jobs! The people must be left to own health and refer only those diseases and conditions they cannot handle to clinics and hospitals. In view of inadequate numbers of medical practitioners with the South African Health Service this finding is critical. Health and health care belong to families and if South Africa intends implementing primary health care strategies fully home care by families could be the starting point.

The involvement by indigenous healers of bomnaya-botsebi37 in maternal and child health care cannot be discounted. In view of current nursing staff shortages brought about partially by voluntary retrenchments community maternity helpers who volunteer to provide health services needs to be encouraged, especially in view of the cost constraints within the country and the escalating costs of medical care. The fact that indigenous healers acknowledge that there are diseases and conditions that are successfully treated by formal health care workers indicates that they have insight into their own short-comings. It is in these areas of deficiencies where cross-referral must be strongly encouraged.

That indigenous healers are community-based practitioners is an indisputable fact. The cause, the prevention and the curing of diseases or health problems are rooted in the community. In turn it is the community that assists in the healing process since healing activities take place there. This is so, especially in incidences of rituals, ritual cleansings and ceremonial offerings to the ancestors. The psychotherapeutic activities used by indigenous healers are based on social foundations which enable healers to persuade communities to take an active part in the therapeutic activities of the patient. Harding (1975:438) has also made this observation. By using collective healing rites to deal with personal relationships through rituals the indigenous healer offers participating persons an opportunity to be actively involved in bringing tensions into the open and reducing strain in their relationships. This process, according to Maclean & Bannerman (1982:1815), helps patients to live at peace with themselves and their environments.

South Africa needs a simple but integrated health care system at community levels; a system that is shaped around the life patterns of the population it serves. What is also needed is a health system that relies to a great extent on available community resources especially those that until now remain untapped. Considering that the users of the services of indigenous healers are not deterred by negative remarks from formal medical practitioners it would appear that the advantages of utilising the services of indigenous healers are more than the disadvantages. Blacket-Sliep (1989:44) mentions that indigenous healers are

37Voluntary maternity helpers.
effective. Indigenous African healers encourage the use of preventive health and their services are readily available to the community and therefore less expensive (Blacket-Sliep, 1989:43).

Treatment prescribed by medical practitioners may fail to cure the disease despite effective pharmacologic action when the patient fails to complete the prescription or to understand the practitioner’s rationale for his diagnosis (Stimson, 1974:98). The argument therefore that contemporary medical practice is opposed to lay expectations because physicians diagnose and treat diseases whereas patients suffer illnesses could be true (Kleinman et al., 1978:251). The implication is that unlike formal medical practitioners indigenous healers diagnose illness of and treat people who suffer from illness. This holistic approach is basic to relevant and acceptable health care; and if primary health care is to be a success in South Africa the model used by indigenous healers needs to be seriously considered and implement in all health care services.

Summary

In this chapter the findings of data analysed in Chapter 4 have been discussed. Chapter 6 presents a theoretical framework and the operational model for this study.
CHAPTER 6

Theoretical Framework

The world of everyday is not only taken for granted as reality by the ordinary members of society in the subjective meaningful conduct of their lives. It is a world that originates in their thoughts and actions, and is maintained as real by these (Berger & Luckman, 1967:19-20).

(We are) being challenged to create alternative procedures which fit those who view the world in ways which are other than Western (Lifschitz, 1989:50).

Introduction

South Africa is faced with the kind of health care reform that needs commitment to rapid change in the field of health care because the innovative achievements in biomedical science and health information systems has not equally-matched the nationwide planning and organization of the delivery of health care services in this country. Since indigenous healers provide health services to the majority of South Africans and since indigenous healing has managed to adjust to the changes brought about by population movements it is anticipated that indigenous African healers will continue to receive support from both the rural and urban communities they serve. The question then addressed in this thesis is:

How do indigenous African healers contribute to health care among South African blacks residing in the Northwest Province?

Cooperation

Among the proponents of collaboration between western-trained health care workers and indigenous African healers are those who on the one hand support this move; while on the other hand there are those who rule out the possibility of collaboration because they regard indigenous African healers as incompetent (Kierman, 1978:1073) and unlearned in matters relating to the administering of proper health care. Practitioners in the field of mental health have in particular urged the integration of formal and indigenous health care systems due to the important role indigenous African healers play, particularly in the fields of psychiatry and psychotherapy (Rappaport & Rappaport, 1981:775; MacClean & Bannerman, 1982:1815; Pearce, 1982:1611). Different authors have also studied and indicated the therapeutic techniques used by both types of practitioners (Cheetham & Griffiths, 1982:954; Torrey, 1972:74-75; Frank, 1973:56; Lambo, 1960:467); and collaborative health work between formal health care workers and indigenous African healers is encouraged when dealing with the different cultural groups (Abad et al, 1974:589).

A functional analysis of indigenous healing by Rappaport and Rappaport (1981:775) supports Frank's (1973:59) contention that there are possibilities for indigenous healers and formal western health care workers to coexist in a given culture. Lambo stated, “The idea is not to throw the baby out with the bath water. My cry to Africa ... is innovation, not imitation” (Ityavyar, 1982:5). While it is acknowledged that
the two kinds of healing systems exist alongside each other there is little or no communication between the practitioners of these systems (Editorial, 1982:1).

There are indications that African patients go to formal health care services if their symptoms persist (Ityavyar, 1982:6). One study indicates that formal medical practitioners who were at one stage in their lives treated by indigenous healers were unwilling to refer patients to healers even when they have seen the benefits of treatment given by indigenous healers (Editorial, 1982:1). The problem therefore does not appear to lie with the users of both health services; it appears that the primary issue is the working together of practitioners in the two systems. Therefore, acceptance of the need to transform and harmonize the health care services of indigenous healers and formal health care workers should be realistically faced. Ademuwagun (1974:56) criticizes the attitudes and actions of formal health care workers when he holds that it is useless for formal health care workers to continually engage in “make-believe, falling prey to parochial false pride”. Since both health care systems have their own values and limitations (Ityavyar, 1982:6) cooperation between the two types of health care workers is crucial.

The view in South Africa is that indigenous African healers should not form part of the public health service; but that they should be recognised as an important component of the broad primary health care team.

In China, in spite of the lack of governmental support for indigenous Chinese practices (Ooi, 1991:216) these healing practices endured and have led to reorganization of the provision of health care services. China’s solutions to its health problems stem from adapting its health care service by integrating indigenous healers into the formal health service and by ensuring that local communities care for their own health needs (Rifkin, 1972:1-12).

In African countries other than South Africa the involvement of indigenous healers in the delivery of health care is a result of shortages in western-trained medical practitioners. There is also a plea for co-existence in clinics so that choices between the two types of health care are offered to patients (Karlson & Moloantoa, 1984:29). Co-existence is important when taking into account that indigenous healers do recognise the clinical patterns of certain conditions peculiar to the ethnic groups they serve (Stott, 1973:335). Nqubane (1976:325) indicates the breadth of the Zulu medical system with reference to the positions of the people and their “relation to each other, to the environment, to the ancestors and to the mystical forces which produce pollution”. This observation although applied to a specific ethnic group applies to most South African blacks. Thus this model of co-existence should not only be viewed in terms of manpower shortages (Rappaport & Rappaport, 1981:779) but also in terms of the provision of relevant care with indigenous healer taking his legitimate and rightful position in the provision of culture-congruent health care.

Smith (1994:338) states that a health care system that is consumer-focused and comprehensive in respect to the patient, the family and the community is an important aspect of health care reform. In this author’s opinion, the real solution to the problem of health care reconstruction is collaboration.
multidisciplinary non-hierarchical team practising in community-based settings where the users reside is imperative for the delivery of the right kinds of service at the right places, at the right times. This multidisciplinary approach will thus decrease the costs of health care and prevent diseases at all levels (Smith, 1994:338).

Indigenous and formal health service workers exist parallel to one another with, at the present time, no possibility of integration. It appears to be highly unlikely that indigenous healers will choose to study western medicine; nor is it likely that formal health care workers untrained in indigenous healing will undertake such practices even though a closer working relationship between indigenous healers and formal health care workers is important to the furthering of national health care services. Co-existence would serve to increase the cultural sensitivity and understanding of the fears of patients by formal health care workers (Voorhoeve, 1966:78) and would also lead to a better understanding within both groups of the health needs of most of the users of health services. Young (1983:1209) supports Yaiyeoba’s (1988:182) suggestion that the collaborative process should be a gradual one initiated at administrative levels until such time that indigenous healers are “educated and well organized and can understand what they can” about the formal health care sector.

However, the issue is that education and learning should be a two-way process wherein the western-trained health worker also becomes aware that indigenous healers have something to offer and are willing to learn from them. Cooperation will also allow for a cross-pollination of ideas between the two types of workers to take place so that change does not occur solely on the side of indigenous healers. It would mean that formal health care workers have to accept that they also have something to learn from indigenous healers. Cooperation of this nature then serves a dual purpose, proving to be mutually beneficial for both indigenous healers and health care workers, and the community as a whole.

Mutual acceptance of the two systems will encourage cross-referral between healers and formal health care practitioners so that referrals between the two parties become routine and do not flow solely from indigenous healers. Facilitation of the collaborative process will depend on development between the two parties of a relationship based on trust. According to McEwen (1994:304), this multidisciplinary collaboration must of necessity extend beyond the borders of communication between nurses and physicians to communication between all team members — including indigenous healers. Sherwen (1990:2) concludes that no group of professionals practising alone can deliver true quality care. Such care is the result of group efforts.

**Theoretical Models**

The benefits of the two systems of health care may not be fully realized unless practitioners are able to provide care in such a way that it is socially acceptable to their clients (Anderson, 1994:137). A study
undertaken by Anderson shows that health professionals are not attentive to the socio-cultural context of health care and are often unaware of the complexity of factors influencing a patient's response to professional health care. As a result the cultural meaning shaping a patient's experiences is not taken into consideration in the planning of care (Anderson, 1994:137). The author further maintains that if these conceptual differences remain unreconciled the professional diagnosis will have no meaning for the patient and the recommended treatment unlikely to be followed. Bolman's Bridging Model (1968:126) suggests the use of at least two therapists for “bridging” purposes — one representing each culture. His model also suggests cross-cultural collaboration with indigenous healers since by ignoring the complex cultural dynamics influencing the patient's behaviour the health worker runs the risk of defining the health problem and treating it from a totally different perspective than from that of the patient.

The What — Why Model

Rappaport and Rappaport (1981:775) suggest a What — Why Model in which the western-trained health worker focuses on what is wrong with the patient and attempts to treat the symptoms. Conversely the indigenous healer focuses on why the health problem occurred and addresses those anxieties relating to the cause of the health problem. The model provides that multiple factors be considered in the provision of health care and enables indigenous healers to take their rightful places in the system for delivery of national health care.

Anderson's Nurse — Client Negotiation Model

This theory acknowledges the differences extant between health workers (nurses) and patients regarding notions of health, illness and treatment and attempts to bridge the gaps between scientific and popular (patients') perspectives (Anderson, 1994:134). The model also regards the healer as a source of power who prescribes the manner in which members of the community should behave when they are ill. Negotiations take place within the context of the patient-practitioner encounter. Nursing care intervention is socially and culturally constructed in context by the health care provider by negotiating between scientific and indigenous healing perspectives. In this way the health worker collaborates with the patient in the provision of health care (Lea, 1994:311). This enables the health worker to step out of an ethno-centric professional framework and to recognise clinical reality as culturally constructed and pluralistic (Anderson, 1994:139). There is also an exchange of information between the health care worker and the patient so that the situation is understood from the viewpoints of both the patient and the health care worker. It is through this culturally constructed and pluralistic approach that they both can then agree on how best to achieve those goals that are in the best interest of the patient (Anderson, 1994:137).
Leininger’s Trans-Cultural Health Care Model

This model takes into consideration individuals and groups, their beliefs and value systems; and these specific cultural needs form the basis or the means through which the delivery of satisfactory health care to the people can be accomplished. When health workers fail to recognise the cultural needs of the people less effective health practices are bound to result and those being served are disadvantaged.

The foundation on which Leininger’s model stands is that health care should be derived from the study of beliefs, values and health care behaviours so that health practitioners can identify and provide culturally-based and culture-specific care both beneficial to and congruent with the needs of their patients. According to Leininger such health care practices should be universally exercised (1980:210). The model also holds that culture determines most of the kinds of care desired by cultural groups and that knowledge of that particular culture is therefore needed by care-givers. It also promotes the premise that local knowledge, cultural views and experiences are important determinants within the constructs of planning and implementing effective health care (Leininger, 1978, 33-34).

Since this theory specifically addresses nurses and nursing care the following definitions are offered for clarity in the description, interpretation and prediction of nursing care (Leininger, 1980:210):

- **Nursing** refers to learned humanistic arts and sciences focusing on personalized (individual or group) caring behaviour directed at the promotion and maintenance of health and having physical, psycho-socio-cultural significance and meaning to those being assisted by care-givers (Leininger, 1978:33).
- **Care** refers to phenomena related to assisting, supporting or enabling behaviour(s) towards or for another individual (or group) with needs (evident or anticipated) to ameliorate or improve a human condition or way of life (Leininger, 1988:158).
- **Health** refers to a state of well-being that is culturally defined, valued and practised which reflects the ability of the individual or group to perform daily activities in a culturally satisfactory manner (Leininger, 1988:156).
- **Culture** refers to learned and transmitted knowledge about a particular group with its beliefs, lifestyle practices and rules of behaviour which guides the group in patterned ways in its thinking and actions (Leininger, 1978:491). It is a dominant force in determining health-illness care patterns and behaviour (Leininger, 1978:60).
- **Sickness** refers to a cultural phenomenon which depends on cultural definition (Leininger, 1984:72-73).
- **Cultural value** refers to highly preferred or desirable ways of acting or knowing something that is often sustained by a culture over a period of time and controls one’s actions or decisions (Leininger, 1980:209).
Culture care diversity refers to the differences of assistive, supportive or facilitative acts towards or for another individual or that are derived from a specific culture to improve or ameliorate a human condition or way of life (Leininger, 1980:210).

Cultural care maintenance refers to the culturally-based assistive, facilitative or enabling phenomenon that helps individuals preserve or maintain favourable health and caring ways of life (Leininger, 1980:210).

Cultural care accommodation or negotiation refers to those culturally-based assistive, facilitative or enabling phenomena which reflect ways in which to adapt, negotiate or adjust to individual client or group health care and ways of life (Leininger, 1980:210).

Cultural care re-patterning or restructuring refers to reconstructed or altered designs which help clients change to health or life patterns that are meaningful to them (Leininger, 1980:210).

The relationship and structure of Leininger's model is depicted in the form of a Sunrise Model thus enabling one to view the manner in which the different components influence health care and the health status of individuals, families and groups. It assists one in conceptualizing the theory's different components and the manner in which these components interact with one another (Leininger, 1980:211).

The above-described model helps the health worker to expand his/her knowledge and to enter into and understand the broad world view of the patient (Leininger, 1984:155).

The Situation in Africa

Nigeria has a joint school of indigenous and western medicine designed to integrate the two systems of care (Dennis, 1978:64) while Ghana has opted for cooperation between indigenous healers and western-trained medical practitioners (Sarpong, 1985:8). Swaziland has also incorporated indigenous healers at the cooperative level so that a better relationship exists between indigenous healers and formal health care workers. This relationship facilitates routine referral between the two sectors (Green & Makhubu, 1984:1077). Indigenous healers are currently given the same status as western trained medical practitioners in this integration of the two systems of health care (Maseko, 1991:12). In Botswana indigenous healers are fully integrated into the formal health services (Satugard, 1989:122); but whether indigenous healers occupy the same status as western trained medical practitioners is not clear. Zimbabwe opted for co-existence between healers and the National Health Service where the two systems cooperate; however, indigenous healers remain outside the control of the government (Chavunduka, 1991:12). Although South Africa advocates cooperation with indigenous healers (ANC, 1994:55) there is at present no suggested model of operation for this proposed cooperation. Therefore, the following model of cooperation is suggested for use in South Africa and the Northwest Province:
The Cross-Cultural Collaborative Health Care (CCHC) Model

A simple three level health care model of collaboration has been developed by the researcher for use in conceptualizing the provision of health care in the Northwest Province and for the “rainbow nation” of South Africa (see Figure 11, page 130). The CCHC Model reflects the trends and perspectives found in the literature and theoretical models previously discussed in this chapter.

Level 1: Preventive and Promotive Care

At this level the individual person is the central focus of health care. The model regards the individual as a responsible self-directing person capable of maintaining his health or that of his family, of preventing diseases and caring for himself. The model also recognizes the individual as someone in need of a system of comprehensive health care that is compatible with his/her cultural expectations. The individual is also regarded as a partner in health care, influenced by the socio-cultural beliefs, values, life-styles, health care patterns, cultural laws and environmental factors surrounding him/her.

At Level 1 both formal and indigenous measures are needed and used for prevention of diseases and promotion of health; and both indigenous healers and formal health care workers are utilized for purposes of health care.

Level 2: Decision-Making

When disease has set in the patient (man) decides on the type of health care worker to consult. Either the formal health care worker (in the clinic) or the indigenous healer is chosen by the patient and/or his/her family depending on the perceived cause of the illness.

Level 3: Collaboration/Negotiation

When an illness manifests itself the patient consult formal health care workers in the clinic for relief of symptoms, treatment of major and minor ailments and surgical operations. If the patient is satisfied he is discharged. If he is dissatisfied he consults the indigenous healer. Those aspects that, in the opinion of the patient, can be best addressed by the healer — such as the question “Why?”, the social and mental aspects of health and the rituals and sacrifices — will be addressed at this level. Sacrificial offerings and all ancestor-related issues will be addressed by the healer for, according to Twumasi (1972:57), these supernatural theoretical aspects serve to reinforce the mental and physical well-being of the person or group concerned. The order of consultation is unimportant. If the patient is satisfied he is discharged.
Figure 11: The Cross-Cultural Collaborative Health Care (CCHC) Model®
At Level 3 negotiations take place between the formal health care worker and the patient. There is an exchange of information between formal health workers and the patient. Both negotiate about the best route to take in handling the patient's health problem. The patient learns about his problem from the nurse and the nurse learns about the cultural viewpoint of the patient regarding the health problem at hand. The nurse, the patient and the healer become cooperative partners in caring for the patient. If the patient wants to consult the healer he is allowed, if he/she wants to consult the formal health worker the healer should respect that decision. It is the patient who dictates the terms of his/her health care so that only relevant and culture-congruent care is provided by both the formal health worker and the indigenous healer. Sensitivity on the part of the formal health worker to the cultural needs of the patient is important so that health assessment by the community nurse is culture-sensitive.

In this manner formal health care workers develop knowledge about the different cultural groups with whom they come in contact the objective of which is to render relevant care. Culture patterns the way in which illness is defined in any given situation and identifies appropriate health-seeking behaviour. Tshotsho (1993:28) mentions that without any awareness of the cultural world views of patients nurses are likely to make erroneous decisions and initiate ineffective nursing intervention. To eliminate these possibilities periodic clinical conferences will be held between the healer and the nurse in order to clarify issues of common concern. Cross-referral then becomes a two-way process between the healer and the community health nurse.

Making the Model Operational

Greater insight and development is needed in the aspects of healing particularly in relation to health and the broader socio-political milieu. The essential and desirable components of primary health care carry with them complex policy and operational implications. Recognition of the African world view could contribute to a positive paradigm shift in the delivery of community health care services in the Northwest Province in particular and in South Africa in general. Collaboration and integration of preventive, promotive curative and rehabilitative care and social development needs coordinated networks and linkages within the national health care delivery system and across a range of sectors. Such cooperation could take place at peripheral clinic levels. Referral could be directly to the out-patient departments in hospitals or to local clinics by healers and to the healer by formal health care workers. Any educational health programmes will have to take these into account. Health and nursing education programmes will have to include some anthropological aspects which cover issues related to health. Health workers will have to recognise the additional roles they will have to assume in terms of negotiation, advocacy, ability to interact across a broad range of interest groups and assuming greater responsibility and accountability to the communities they serve.

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Chapter 6 — Theoretical Framework: p.131
Summary

In this chapter views on different and relevant theoretical frameworks for health care have been presented. The African situation relating to collaborative efforts have been outlines. Finally a theoretical model of collaboration is suggested for the Northwest Province and South Africa. The manner in which the model can be operationalized is outlined. The next section deals with research methodology.
CHAPTER 7

Summary, Conclusions and Recommendations

Yiva imithandazo yethu
Usisikele
yihla, yihla, yihla Moya
Yihla Moya Oyingwile

Summary

In Chapter 1 the problem which formed the basis of this study was presented. It has been pointed out that formal medical services have failed to provide adequate health care to the majority of the people. It has also been indicated that primary health care has been unsuccessful due to the lack of clarity of its definition. The result is that health care remains inaccessible and non-affordable for most people in spite of the new health policy for maternal and child health services. Since black people utilize indigenous healers for health care purposes the challenge therefore was to determine the role indigenous African healers play in the prevention of disease and promotion of health. In light of this problem the following five objectives were formulated for this study:

1. exploring the role played by indigenous African healers in the prevention of diseases and promotion of health care at primary, secondary and tertiary levels;
2. finding out which health problems are taken to indigenous healers;
3. identifying the diseases indigenous healers prevent and those they treat;
4. determining the level at which cooperation with formal health care workers could take place; and
5. designing a cooperative model that could be used by both indigenous healers and formal health care workers in the provision of community health care in the Northwest Province.

Pursuant to these objectives the researcher, in Chapter 2, undertook a literature review to demonstrate the involvement of healers in the provision of health care. It was noted that there is a connection between the African world view of religion and matters pertaining to good health. This section also assisted in identifying aspects of the theoretical frameworks addressed in Chapter 6.

Chapter 3 presented the research methodology undertaken during this study. The type of study, sampling procedures and ethical considerations were described. Methods of data collection, their qualification and validation were offered; and Leininger’s assessment domain was used as a framework of reference for analysing the data. The analysis of data collected in this resource was presented in Chapter 4. It was found that indigenous African healers are involved in the prevention of diseases and promotion of health at primary and secondary levels. Preventive and promotive health measures were found to be applied to pregnant mothers, children and widowed persons. It was also found that different types of conditions are diagnosed and treated by indigenous healers. It is also shown that there is a trend amongst users to utilize...
both indigenous healers and clinic or hospital workers and practitioners. It was further found that mental illness appears to be the area in which indigenous are most good at. The finding applies to infertility and impotence. The study related certain sexually transmitted diseases unknown to western-trained personnel that could have social implications and that are only treatable by indigenous healers. The findings further showed that there are certain culturally-bound diseases taken to indigenous healers for diagnosis, treatment and care. It was also found that there is a one-way referral of patients to clinics and hospital by indigenous healers; that the reverse did not occur. The study also showed that healers are willing to cooperate with formal health care workers at any level but are not treated with respect by community health nurses in the clinics.

Against the background of data analysed in Chapter 4 the researcher presents a discussion of the data in Chapter 5. It is argued in this chapter that indigenous healers provide first-contact health care at grassroots levels; that care is provided by healers in accordance with the cultural values of the people and is therefore relevant. It is argued that the procedures used in treatment and care follow an orderly pattern but that there are certain aspects which could prove harmful to health.

Following this discussion a theoretical framework was discussed in Chapter 6 in which a cross-cultural collaborative health care model is presented. Three levels of operation wherein the client is involved throughout was proposed; and the manner in which the model could operate was presented.

In this chapter the set objectives will be evaluated to determine whether they have been achieved.

Objectives

Objective 1

This objective was aimed at exploring the role played by Indigenous African healers in the prevention of diseases at primary, secondary and tertiary levels of prevention.

In this study it was revealed that indigenous healers are first-contact private family health practitioners. Information from healers, users of formal health services and from observation shows that indigenous healers are involved in the prevention of diseases and promotion of health (see Tables 7, 8, 24,29,30,31). It was revealed that their activities take place within a particular cultural values system functioning within an ethnocentric framework (see Tables 6 and 19).

Information also shows that indigenous African healers are involved in the treatment of diseases and other health problems (see Tables 6, 8,16,13, 24). Such treat and care includes the use of life-caring rituals and taboos (see Table 10).

Data gathered from users of formal health care services reveals that indigenous healers care for the chronically ill at $\text{diagelong}^1$ (see Table 28). This is undertaken to provide rehabilitative care and or

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1The healers' own hospitals.
recuperation. Information also revealed that where indigenous healers cannot cope they employ the use of health support systems (see Table 26). Such health support systems are socio-cultural in nature and are regarded as acceptable.

It was revealed that indigenous healers are private practitioners involved in preventive health care for families (see Table 24); that the types of preventive health care activities in which they are involved cannot be provided by formal health workers since the latter have not been trained in indigenous healing techniques. Performance of life-caring rituals as prescribed by healers form part of the therapy and healing process (see Table 16). Rituals are also used as preventive and curative means for culture-bound syndromes.

Objective 2

This objective sought to determine health problems taken to indigenous healers. The study showed these health problems to be grouped in the following categories:

- **Category 1 — Children's diseases:** This category included both preventable and curable diseases and are shown in Table 19.

- **Category 2:** Included gynaecological and sexual problems as well as sexually-transmitted diseases. The lists of these problems appear in Tables 20 and 21.

- **Category 3 — General conditions:** With the exception of (Sejeso) these are conditions affecting all sexes and age groups that are usually taken to clinics and/or hospitals for treatment (see Table 22).

- **Category 4 — Family health problems:** These are problems peculiar to black families (see Tables 23 and 24).

- **Category 5 — Includes culture-bound syndromes:** These are health problems that exist within the context of a particular culture and that require cultural methods of treatment. In Chapter 2 questions were raised about why hospital patients "drop our" or default and where they "drop into". It is shown in this study that when they default they drop into the service of indigenous healers. The findings show that a wide range of health problems are taken to indigenous healers.

Objective 3

This objective was aimed at identifying diseases that indigenous healers prevent and those that they treat. Information from both healers and users of formal health care services showed that children's diseases, listed in Tables 19 and 32, are treated by indigenous healers. Table 29 shows a list of preventable diseases in children.

Information also indicates that certain adult diseases and family health problems are preventable (see Table 30).
Objective 4

This objective was aimed at determining the levels at which cooperation could take place. Information from both healers and users of formal health services show that cooperation with the nurses at clinic levels is desirable. The reasons given centred around the taboos related to traditional medical practices. Some respondents however expressed concern about the attitudes of community health nurses and would prefer to cooperate at hospital levels with medical practitioners.

Indigenous healers prefer to practice from within the communities with their homes as their base of operation while at the same time enjoying a cross-referral of patients. The current one-way referral of patients from the healers to formal health workers was also of concern to indigenous healers.

Objective 5

These objective was derived at findings a cooperative model that could be used by formal health workers and indigenous healers to provide relevant and acceptable health service. A cross-cultural collaborative health care model was developed (see page 130) to meet this objective. The model is considered relevant for the provision of community health services within black communities. In view of the multicultural nature of the South African population it could also be adopted to suit all community health care situations.

All the objectives discussed above lead to the conclusion that indigenous healers provide health services to the community; and that there are similarities and diversities in the manner in which care is provided by healers and formal health workers. A cross-cultural collaborative health care model was found to be suitable for providing community health services.

Conclusions

From the findings in this study it is concluded that indigenous African healers are involved in providing primary health care through preventing diseases and promoting health by being the first contact persons in the provision of a preventive health service providing curative services through treatment and care forms the second level of their health care activities. Through curative treatments they prevent the development of chronicity. Rehabilitative care at diagelong

\[\text{diagelong}\]

is their last attempt to rehabilitate and sometimes cure the disease. It is also concluded that the care indigenous African healers provide is acceptable, readily available and affordable. It is concluded that healers go beyond prevention of physical conditions. The involvement of healers and ancestors impacts directly on the social, emotional and religious aspects of health. This holistic approach contributes to the social well-being to health healing and wellness in people. It is also concluded that for as long as formal health care services fail to meet the cultural health needs of black patients indigenous African healers will remain active, community-based first contact public health workers.

\[\text{Indigenous healers' hospitals.}\]

SN Shai-Mahoko: The role of Indigenous Healers in Disease Prevention... Chapter 7 — Summary: p.136
Recommendations

As a result of this study the following recommendations are made:

1. The department of Health at the national level should ensure that cooperation between indigenous African healers and formal health care workers takes place. Mere indication of the above in the National Health Plan (1994) without follow-up mechanisms to ensure that the process of cooperation proceeds is ineffective.

2. The cross-cultural collaborative health care model presented in this study should be implemented at clinic levels. This is to ensure that indigenous healers practising in their homes observe health taboos and rituals without obstacles.

3. In the eyes of the users of both systems of health care a skewed and informal one-way working relationship exists between healers and formal health workers. Co-operation should go beyond informal operations and should expand beyond clinic levels where necessary in order to expand the combination of both systems of health care at all levels of the service. Referral of patients should be a two-way process in order to foster strong collaborative links between formal health care workers and indigenous healers. The existing one-way referral system raises suspicions on the part of indigenous healers. A mechanism of referring patients to both health care delivery systems should be worked out by the practitioners of both health care systems.

4. The attitudes of clinic nurses towards indigenous healers needs to change. For as long as formal health care workers continue to undermine indigenous healers and their services implementing collaboration will be difficult. An urgent and strong educational campaign directed at changing the attitudes of clinic personnel is needed. The attitudes of professional health workers towards indigenous healers needs to change from negative to positive. A positive change in attitude could facilitate communication between the practices of both health services. It could also bring about a two-way referral system of patients to both health systems.

5. Community health education programmes relating to the prevention of diarrhoea and vomiting in children by healers must be developed. Mothers must be encouraged to prevent diarrhoea and vomiting through indigenous medicine. This aspect should be included in the immunization schedule. Indigenous healers specializing in the prevention of paediatric diseases should be identified and made known. All healers should know how to prepare and administer oral
rehydration therapy to complete their medicines for children who come with diarrhoea and vomiting.

6. Indigenous healers should form an active part of the psychiatric team and be consulted in all cases of mental illness especially those in hospitals. The healer's assessment would screen those that need institutionalization and those that should be treated by them in the community.
   • It should be policy that mentally ill patients should be treated by indigenous healers as part of community psychiatric services. Only violent patients should be taken to hospitals and returned to healers when stabilized. Such an administrative policy would benefit patients and relieve the psychiatric hospital's of overcrowding. This recommendation calls for the establishment of strong community psychiatric services.

7. Basic methods of sterilization such as boiling, flaming and the use of spirits should be taught to healers. Personal and environmental hygiene should be emphasized.

8. Education on home accidents and their causes should be provided in relation to medicinal herbs and used instruments. Consultation rooms and dispensaries should be kept locked when not in use.
   • Cultural care aspects should form part of the curricula of the students of nursing and of medical students to introduce them to the dynamics of cultural health care. Nursing education in the field of community health should be responsive to the needs of diverse communities. The community health curriculum of nurses and medical practitioners should include aspects of traditional medicine. Courses such as Public Administration should be replaced by courses relevant to community need, eg Anthropology.

9. This research should contribute to action and dialogue between the practitioners of the two health care delivery systems with the view to prompt further mechanisms of cooperation.
   • Education of indigenous healers by formal health professionals on other methods of health assessment is crucial. Workshops on listening to normal heart and lung sounds and referral of all abnormal sounds to clinic would improve early detection of diseases. Education about simple local technology for rehydration purposes could improve the services of healers in relation to the treatment of gastroenteritis (phogwana) and prevention of child deaths.
10. Care should be provided at home by family members. Only conditions that are beyond the family's management abilities should be brought to health centres. Community health centres and clinics should be adequately manned to enable nurses to move within the families in each catchment area to do home visits and check on the health of communities.

11. Further research into the plants used for healing purposes is needed to determine their botanical identification, their active chemical compounds, their pharmacological actions and toxicity. This kind of research could open up an economic avenue and bring about economic development in indigenous healing.

12. People should be encouraged to consult indigenous healers for those conditions and diseases for which medical science has no cure and for culture-bound syndromes. Mentally ill patients admitted to hospital or seen in the clinic should be referred to indigenous healers. It has been shown that such patients are better treated by indigenous healers (Griffiths & Cheetham).

13. The proposed model of health care is an attempt to harmonize the two systems of health care, each operating within its own sphere and each renewing and enriching itself and the other. It is recommended that the model be put into operations at clinic level, including hospital out-patient departments. Its use could be expanded to other areas as the need arises.

14. Policy makers should enlist their will and commitment to change relating to cooperation between indigenous healers and formal health workers. Specific guidelines of cooperation should be formulated and enforced at national level to ensure that change is effected.
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SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... References: p.145


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SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... References : p.147


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SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... References: p.157


Rodgers, G.E. 1993. Healers and ways of healing: a comparison between ancestral healers and Christian healers in a village section in Gazankulu. (A dissertation submitted to the Faculty of Arts, University of Witwatersrand, Johannesburg for the Degree BA Honours Social Anthropology.)


SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... References: p.160
References:


**Presentations**


### Additional Readings


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SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... References: p.163


Jansen, F.F. 1982. An investigation into the scope of medical anthropology and the possibility of improving the effectiveness of cross-cultural western medical services for South African blacks. (A dissertation submitted in fulfilment for the degree of Magister Artium in the Faculty of Arts, University of Port Elizabeth.)


**CD Roms, Graphics and Photography**


Annexure 1

Indigenous Healers' Code of Ethics: The Healer's Oath
I, a healer, invoking all my ancestral shades to be my witnesses, that I will fulfil this oath and this written covenant to the best of my ability and judgement.

'I will look upon him who shall have taught me this art even as one of my own parents. I will share my substance with him, and I will supply his necessities if he be in need. I will regard his offspring even as my own brethren, and I will teach them this art, if they would learn it, without fee or covenant. I will impart this art by precept, by lecture and by every mode of teaching, not only to my own sons but to the sons of him who has taught me and to disciples bound by covenant and oath, according to the law of medicine.

'The regimen I adopt shall be for the benefit of the patients according to my ability and judgement, and not for their hurt or for any wrong. I will give no deadly drug to any, though it be asked of me, nor will I counsel such.

'Whatsoever house I enter, there will I go for the benefit of the sick, refraining from all wrongdoing or corruption. Whatsoever things I see or hear concerning the life of men, in my attendance on the sick or even apart therefrom, which ought not to be noised abroad, I will keep silence thereon, counting such things to be as sacred secrets. Pure will I keep my life and my healing art.

AMEN
Annexure 2

Certificate: Association of Herbalists of Venda (Proprietary)

and

Certification to Practice: South African Traditional Healers Council
ASSOCIATION OF HERBALISTS OF VENDA (PROPRIETARY)

Association registered under Act No. 1973 of RSA
Registered No. 88-0031

P.O. Box 785
Sibasa
Venda

MUSHONGA U A PHODZA

CERTIFICATE

THIS IS TO CERTIFY THAT

WAS ACCEPTED BY THE ASSOCIATION OF HERBALISTS OF VENDA (PTY) LTD, AS A DULLY QUALIFIED MEMBER AND IS HEREBY RECOGNISED AS A HERBALIST, TO SELL MEDICINE AND HERBS, TO TRAIN PEOPLE AS HERBALISTS AND TO CURE AND HEAL.

PRESIDENT: 
SECRETARY/TREASURER: DATE: 

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SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention ... Annexures: p.170
We certify that

DR. PETRU HETHURAYANI

Having subscribed to the objects and aims of The South African Traditional Healers Council and having complied with the requirements of this council's qualification committee to perform the function of

has been issued with the

FINAL CERTIFICATE TO PRACTICE

Certified at a congregation of the Council

on the day of 19

CHAIRMAN OF QUALIFICATION COMMITTEE

PRESIDENT
Annexure 3

Request for Consent to Conduct Research
Annexure 3

Request for Consent to Conduct Research and Permission to Conduct Research

Box 4391
Mmabatho
1995 — 01 — 15
Request for Consent to Conduct Research

I am a D.Litt e Phil student at the University of South Africa. My student number is 272-773-0. Presently I am engaged in a research project titled “The role of indigenous healers in disease prevention and health promotion among South African blacks: a case study of the Northwest Province”, under the supervision of Professor MJ Dreyer and Dr OC Makhubela-Nkondo of the Department of Nursing Science, UNISA.

The purposes of this study are to 1) find out how indigenous healers contribute to health care among the black people; and 2) to formulate guidelines for cooperation between the healers and formal health workers.

To complete this study I need to conduct interviews with healers and users of formal health services for a duration of about 60 — 75 minutes. The interviews will be audio-taped for verification of findings by an independent nurse researcher and if needed by my supervisors. In order to protect your name and dignity I undertake to do the following:

- Omit or disguise your name when discussing information pertaining to the study;
- Keep all raw data under lock and key when not in use;
- Ensure that other than myself, co-coders and my supervisors, no one gains access to the raw data;
- Erase raw data as soon as is possible;
- Leave you with my contact address and telephone numbers in case you need to see or contact me in connection with any matter arising out of this study;
- Provide you with a summary of the research findings in a language preferable to you, should you need this; and
- Terminate the interview at any stage if you so require.

Your participation in this study has the possibility of benefiting the users of health services and restructuring of health services in this country and indigenous healers in general by having the opportunity to verbalize your experiences of care activities for about 60 — 75 minutes. Remember that if you do not want to participate in this study you are free to do so.

SN Shai-Mahoko, RN., M Sc (Nursing)
D. Phil et L.H (Community Health Nursing Science) Student
Annexure 4

Protocol for Co-Coder:

Content Analysis of Data Obtained in Research Project
Dear Colleague:

Please follow the steps below to analyse the data of the transcribed interviews:

1. Read through the following descriptions of Leininger’s (1978:85-105) Domains of Culturalogic Assessment which are used as universal categories.

   1.1 The patterns or life-styles of an individual or cultural group. These are observed life-patterns and styles of health and sickness behaviours. They are observed within the home environment of the individual or cultural group.

   1.2 The specific cultural values, norms and expressions of a client or group regarding the health and caring behaviour of their culture. These constructs are obtained through observations and some are expressed orally or in writing.

   1.3 Cultural taboos and myths about what should be avoided which has the potential to harm oneself or others.

   1.4 The world view and ethnocentric tendencies of an individual or group with regard to their view of health, illness, those who give care and those who receive care.

   1.5 General features perceived by the client (or group) as differences from or similarities to other cultures in or near their environments. This means obtaining information on cross-cultural comparisons of health-illness behaviour and comparing the client’s views in relation to a second culture and to identify why there is a difference.

   1.6 The health and life caring rituals and rites of passage to maintain health and avoid illness. Rituals are a powerful means of reinforcing the carer’s and the patient’s modes of behaviour and can be therapeutic to one’s emotional state by providing reassurance and confidence in one’s expectations.

   1.7 Folk professional health-illness systems which means the local and indigenous ways the people provide health care to their people; roles of local curers and curers. Professional health-illness cultural system refers to the western system of health care.

   1.8 Specific caring behaviour and nursing values, beliefs and practices refers to the types of support systems and activities carried out by the support system.

   1.9 Indicators of cultural changes and acculturation process refer to the extent to which one supports the indigenous culture and the extent to which one adopts a new way of life.

2. Read through all transcripts and underline words and themes.

3. Classify the words and themes into universal categories in relation to the transcultural assessment domains.
4. Cluster those words into themes and sub-categories.

5. Make a comparison of all transcriptions and indicate in each category how many participants used the same words and themes.

6. Identify relationships between major categories and sub-categories.

Thank you

SN Shai-Mahoko
D.Litt et Phil (Community Health Nursing Science) Student
Annexure 5

Transcription of Interview No 7 to Demonstrate the Method of Content Analysis Through Underlining Words and Themes in Setswana and English
Transcription of Interview No 7 to Demonstrate the Method of Content Analysis Through Underlining Words and Themes

in Setswana and English

Key:  Int = Interviewer  Resp = Respondent

Research Question: A ke o ntlhalosetse gore seabe sa dingaka tsa-setso mopholong ke eng.

RESP: Rona dingaka tsa Setswana re a thusa mo kalafing ya setso.

Ke simolola pele kwa ngwaneng. Ngwana ge a sena go tsalwa, o simolla a sirelediwa, a irelwa Ditantanyane.

Ditanatanyane tse ke buang ka tsona ke go thibela dikrempe mo mohubong, go phuthulla ditshika tsa ngwana ka fa gare.

Ge re fetsa foo, go na le thireletso ya malwetsi go soutisiwa, jaaka bolwetsi jwa Tlhogwana. Bolwetsi bo ge bo setse bo tsene ngwana, ngwana o simolla a tsholla. O fellwa ke metsi mo mmeleng. Ge bo topeletse, letlanyana le legagwe o fitlhela le setse le sosobane, le ngaparela bjalo. Bjanong re mo soutisa ka go mo arametsa ka yona meleme ya bana. A ba a thakgiwa, a tshatiwa ka yona.

Meleme ye e arametsang ye e thibela tlhogwana. Fa e le gore ngwana ona tlhogwana e setse e mo tshwere a sa soutisiwa, le teng go na le korametso ya teng ya ge setse tlhogwana ena e mo tsene. Mme gantsi bana ba simolla ke go tshwara ke tlhogwana ge ba simolla go medisa. Ke fao gona fa ditshika di simollang go ngangega teng, e be go wetsa phogo ya ngwana. E a wela. Ngwana a thuba ssssss.

INT: Go thuba ke go kgwa?

RESP: Eng. A thuba kwa tlase, mme ebile a kgwa kwa godimo.

INT: Mmmm!

RESP: Ngwana wo o tla thuba boregerege le botala. A ba thuba le botselha, a sale a thuba le metse. Ke ge tlhogwana e setse e mo tsene. Foo le teng go na le mearametso ye a aramediwang ka yona. Segolothata nna totatota, mo baneng, tota ke kgona ka bona bana thata.

INT : Wena o specialist sa bana!

RESP: Ka bana thata, mo baneng.

INT: Hmmm!

RESP: Go na le bolwetsi jo bongwe gape jwa bana, ba go bulega marago.
INT: Bo bidiwang!
RESP: Bo re bo bitsa re re ke *Kokwana*.
INT: O.K.
RESP: Ehee! Kokwana ye, *ga e nne golo go le gongwe*. Ye e bonalong ka pele go ka bula ngwana mo maragong, ke ye e *leng teng mo mokwatleng*. Ge e le mo mokwatleng, ngwana *wa teng o tshwara ke mokotla*, a be a paltse la le go a ka *tsamaya*. A *nnle ruri fase*. Mokotlo o wa gagwe o, *ga ona maatlha*. Ga o khuthulwe. Le bona ke bolwetsi bongwe bo bo alafiwang. Kokwana ye, o mongwe e nna ka mo teng ga mala ka mo. *Ge e le ka mo teng ga mala, e phidisa nagwana o ka go mo tshabisa dijo, a kgwetse ruri*. Bjaanong bo bokoa ba kokwana bo, ke bokoa bo bana ba bo kgaboletang.
INT: Ke go dirang go kgabolela?
RESP: Ke go akamega. Ke gore *bo na le tshwaetsano*. Go fetelana.
INT: Oooh! Bo a fetela!
RESP: Eng. Bo na le go fetela.
INT: E be e le gore ngwana o bo tsere ka? 
RESP: Ngwana ke a ka kopana le ngwana yo mongwe e le gona ntsa tshwere ke bokoa bo, a fetsa go ka alafiswa; go direlwa kalafi e. *A seke a bile a beelwa malatsi gore a seke a kopana le bana ba bangwe*. Go na le gore a ka tshwaetsana. Bjaanong ge ngwana a tshwere ke bolwetsi bo, a alafelwe gore *a seke a *okama* ba bangwe; go *imela ba bangwe* ge re re go okama. Eng. Ke go imela ba bangwe. Ge o ka seke wa mmereka ka tsela e bjalo, e ka re ge a tswa fa, ge a kopana le ngwana o mongwe, e be bo mo fetela. Bo fetela mo go ene.
INT: Ngwana o a sa dirwang sepe ene?
RESP: Yo o sa dirwang sepe? Ge o ka seke wa dira sepe gore a seke a okama ba bangwe. Bjaanong ge re bo bereka ka tsela ye gore a seke a okama ba bangwe. Re mmereka ka meriri ya gagwe, le dinala tsa gagwe. Re kopanya le melemo ye e phekolang bolwetsi bo. Ngwana ola o kgona go folo. Go na le *tshireletsotse* gape ye e sireletsang bana ge *ba simolla ba medisa* mo ganog. Ba simolla ba fikela thata. Ke nako e ba tshebelaeng ke bokoa. Go na le *ditshireletse* tse re di *apesang bana* ba, gore etle e re ge a medisa, *a seke a kgapiwa ke letshollo le lethatso*.
INT: Mmmmm!
RESP: Go na gape le gore ngwana yona ge a simolla, gongwe ge a tsalwa, *o tsalwa a na le* bokoa bo re bo bitsang re re ke *Makgome*. Le ona malwetsi a a bo Makgome ke a alafa thata.
INT: Makgome?
RESP: Eng, makgome. Nako e ngwwe re bitsa re re ke *Seroma*. Ngwana yo a ka *tswa dintho le mo tlhogong*. A *kgomela diso* tse di tsitsibanyang mmele o otlhe ona, di bile di nyanya le metsi. **Meriri**
Ye e kgotega. Ngwana yo wa be a tshwere ke makgome. Ga ntsi ngwana ge a tshwere ke makgome ya be e le bokoa bo a botsereng mo sebopelong mo motsading wa gagwe.

INT: Mo popelomg ya mme?
RESP: Eng. Mme a ne a na le diso tse re di bitsang re re ke Makgome. Mme makgome a, a tsalwa ke gore mme mongwe wa tla a fetehwe, a seke a krei dipitsana tsa Setswana. A be a tle a imele mo masweng. Ngwana ona a be a na le Makgome. Makgome a, a na le go dira bokoa ba Asthma.

INT: Ooooh!
RESP: A mo thiba mafatlha ngwana yo ge a le ka fa gare bjaana. A tswela ka fa ntle. Bjaanong ge a tswela ka fa ntle, a alafsiwa ka go forolwa.
INT: Go forolwa?
RESP: Eng. A a forolwa.
INT: Kana ge o re go forolwa o ra go dirang? O ra go mo tshatsha mo mmeleng?
INT: Mmmmm!
INT: Jaanong ge re fetela ka fa go bomme?
RESP: Bomme? Ka mo thakoreng la bomme re na le go thusa bomme ba ba sa atlegeng mo peleging. Ba ba tlhokagang thari. Bomme ba ke ba thusa thata. Go na le bomme ba o ka fitlhelang o mongwe a sa bone thari, a na le bokoa re bo bitsa re re ke Sekaku ka fa gare. Ke gore sekaku sena ge se le teng mo mmeng yo, yo a sa tsholeng yo, e ka re mo maragong bjaana, a bo a mela namanyana. O ka re nama, o ka re seso. Motho yo o nang lc sekaKu yo, ga go gantsi a tshola bana. Le ge a ka tshola bana ka letlhogonolo, ba a feta.
INT: Mmm!
RESP: Sekaku se, se na le kalafi ya sona. Sekaku se, re a se senga phakela, se tshasiiwe molemo wa sona. A ba a fiwa molemo e e tshatsweng teng. A ba a fiwa molemo o re o bitsang re re ke Moremela. Moremela o re remelang ka ona. Go na le o mongwe e ka re ge a sena tsalo, mae a gagwe a be a sena menontsha. Go farologana ka gore motho o gore a seke a bana le tsalo, o bone eng ge wena o mo thathloba.
INT: Mmmmm!

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Annexures : p.180
RESP: Ga se ka tsele e le nngwe. Ge mae a gagwe a sena menontsha, go na le molemo wo a o fiwang, wo a o nwang ka mashi. Wo o tiisa menontsha ya gagwe gore a bane le peu, e mele. Ke moremela. Meremela ye, e ka mefuta. Ge o mongwe a ka etsa a sa bone tsalo, e le ge a na le bolowetsi bo re bobitsang re re ke makgome, le ona a thibela tsalo.

INT: Makgome?

RESP: Eng, ona makgome a. O tshwanetse a alafelwe makgome ana, a thatswiwe teng ye ka melemo, a be a fiwe ona molemo gape o re re teng ye ka melemela, o o remelang; O o baakanyang mose. O mongwe o tihoka tsalo, molomo wa tswala ya gagwe o eme ka lethakore.

INT: Ke gore molomo wa popelo?

RESP: Eng. Ge o eme ka lethakore o tshabellwa ke phefo thata. Motho o, re mo sidila, re mo fa melemo ye e baakanyang mose, mme e bile mose o o nse o sidilwa. Re o sidila gore o boe. Ge o siditswe o boetse mo mammong, motho ona o kgona go bona tsalo. Go na le makoa a nna ke tle ke kopane le ona, a makgome gape a tle a be teng le mo go bomme. O fithela bosading ha bona bo dule ditho go fithela le ka mo tase ka fa. Tse di nyanyang metsele tsona. Bolwetsi bo le bona motho wa bona o forolwa pele, a fiwe melemo, a be a fiwe le dipitsana, tse a di nwang. Bolwetsi bo, bo a folo. Go na le bolwetsi gape go mo bomme, bo le bona maungo a bomme le ona a sa berekeng. Mme a sena takatso.

INT: Ke gore mme a sena takatso ya monna?


INT: A bo a nna le takatso?

RESP: A bo a nna le takatso. Go malwetsi gape a bomme, a motho a ka se keng a kgona go ka bona tsalo e le ka tomeletso ya Setswana. Ba editse ka tomeletso ya Setswana ba ba ka bong ba mo hufagela; e ka Setswana re e bitsang re re ke boloi. Go tla thaga gore ge go tlathobiwa, ge go tlathoboliwe gore motho o, se se dirileng bjana ke eng. Le teng le yona e na le kalafi ya yona. Kalafi tse na di tshwane. Di ya ka gore bolwetsi bo bo tlele ka tsele e, bo alafiwa ka molemo o rileng; bo bo tlieng ka tsele e, bo alafiwa ka molemo o rileng. Motho o le yena o kgona go phekolwa go fedisa tomeletso e, a ba atla a kgona go bona bana. Go na le (ke fedisie ka bomme) ka fa tlhakoreng la bontate. Bontate ba na le go tshabella ke malwetsi a tshwaelang, a re a bitsang re re ke bodropo, a khutlego.

INT: A le a bitsang le re ke eng, bodropo?

Motho yo a ne a sa krea kalafi. Eo le yona mothro ge a kopane le yona, ke ye re e bitsang re re ke Seswagadi.

INT: Oooh! Boswagadi!

RESP: Boswagadi. Bjaanong boswagadi bo le bona bo feletsatse bo diretsa rrre khetleng. Khetleng ena e be e fetsa le rre, e mo retsefaletsatse marumo a gagwe a senna. Marumo ana a retsefa, a bo a sa tihole a bereka. Go tlokege gore mothro ona a alafwe, a be a fotediwe ka go diretsa ditootso. Rre ona a be a phela, a mna sentle. Go na le bokoa gape bo bongwe ba borre, bo le ene mae a gagwe a tsalo a se rang menontsha. A ntsa a alafwiwa fela jaaka ge go alafwiwa mme.

INT: Mmmm! Ke gore rre yo ga a kita a dira bana?


INT: Mmmm!

RESP: Bolwetsi bo, mo makgweng, mothro ona o feleletsatse a kgaotswe.

INT: Makgowa ba bo bitsang?

RESP: Ga ke itse gore ka sekgowa ba bo bitsang. Nna ke bo itse ka Setswana. Bolwetsi bo, bo a alafega. Serunya sena se ya alafega. Mme bolwetsi bo ba serunya bo, bona ga ntsi bo tswala ke tomeletso ya Setswana e re e bitsang re re ke boloi.

INT: Mmmm!

RESP: Ke bolwetsi ba moleko. Ga se bolwetsi bo bo tshagang fela. Ke bolwetsi bo bongwe gape bo bo masisi thata. Mothro wa teng ge bo mo dule o kgona go tswa le diboko ntse a phela. Ke bolwetsi bo ke bo alafang boo; bo ba Serunya.

INT: O bo alafa ka serunya?

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Annexures : p.182
RESP: E, e. Ga ke bo alafe ka serunya. Pila-pila serunya se na le pheko tseng tse ke bo alafang ka tsona. Le sona serunya se ka se tsenya. Mme go na le e ngwe ye e kgonang go se thibela gore se seke sa keka. O a se kaya. O a se bofa gore se ikgobokanye golo go le gongwe, bolwetsi bo bo seke ba tsamaya le mmele o. Ge o bo bofile bjalo, ke gona o simolla o bo thapisang, o bo tshela melemo ya bona. Bo a folo bolwetsi bo. Ge bo ne bo setse bo phuntse lerapo bjaanong foore alafa ka meemo ya dipholofolo.

INT: Meemo ke eng?

RESP: Marapo a dipholofolo. Ge o tshela, o simolola o tshela mo lerapong le, gore le tle le lemotangane. Le lemotangane ke marapo a mangwe a, a meemo. O bo o simolla o alafa letlalo lena, le ntho ena, le nama e.

INT: Mmmm!

RESP: Go bolwetsi ba Asthma. Asthma ke a e alafa, mme e bothata. Molemo wa bona, o ke alafang ka ona, o o sa epiweng, ke wa pholofotswana e ngwe e e jang borekhu, ye e jang dinothsi.

INT: Ke eng?

RESP: Magogwe.

INT: Magogwe?


INT: O batla eng mo magogweng?

RESP: Marapo.

INT: O batla marapo fela?

RESP: Ke alafa ka marapo ka gore marapo ke ona a tetseng "honey". A tetseng dinotshe. O alafa ke mmoko o o tetseng dinotshe le marapo a a agileng ke dinotshe.

INT: Mmmm!

RESP: Asthma e ke yona e marapo a a kgonang go e alafa.

INT: O a nwa kgotsa o a thabelwa?

RESP: O a nwa. Eng. O a nosiwa. Asthma e ke bona bo ke bo alafang. Mme ke sokodisiwa ke magogwe. Melemo e mengwe yona e teng, e shota magogwe. Go malwetsi a o ka fithelang a fithelwa ka mo teng ga malapa; a kagiso e seong ka mo teng ga malapa, a a dirwang ke tumeletso ya motho. A kgona go fedisiwa. a a dirwang ke tumeletso ya motho ke kgona go a fedisa. Go mathata a malapa a o fothelang go se na kultwano mo teng ga lapa. Ge a dirilwe ke tumeletso ya motho, a kgona go khuthulega, a fele. Go mathata a lapa a a tle a tsalwe ke go tlhoka bonnete le botshepegi. O mongwe a ba a tswela ko ntle. Ga a tswetse kwa ntle, a batlile molekana kwa ntle, molekane o mongwe ola o fithela a na le poulelo. O bo o fithile a dirile tumeletso ka mo teng ga lapa, a itebaganya le mongwe ka go mo direla moratiso.

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SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Annexures: p.183
INT: Gore a lebelele ene fela?
INT: E tsea nako!
RESP: E tsea nakonyana. Ga e kapejana jaaka ba ba itseng go kgwisa. Jaanong nna ga ke kgwise. Ke a bodisa gore motho a ntse kwa tlase, a seke a kgoroletsega; a kgone gore a tsitoli a bereke. A seke a tshwengwa ke sepe, a mne a itutwe a na le maatla. Ge mokgwelo le o dule, o kgona go mo fa molemo o re reng ke tshedimogo, a ihharabologelwe. Go a kgonega gore a siame, legae le agege pila, le nne sentle, ba sirelediwe.

Mo setswaneng gape re na le batho ba ba simololang go nyalana. Batho mo tlhagong ya rona, ge ba simolla ba nyalana, ba a tshwarwannya setswana gore batho ba, ba seke ba tsenwa ke diphefo fa gare; tse di feleletsang di sentse tlaolo. Go molemo o ba berekiwang ka ona. Ba berekwa bjaana ba tshwarane ka mabogo ge re tiisa lenyalo le. Bjaanong mo setswaneng re berekwa ka go phatsa. Nna ke berekwa ka go phatsa ba tshwarane ka mabogo. Ge re fetsa, kga metsi. Re o fa mosadi wa gagwe a nwa, metsi a a sa tshelweng sepe, nse ba tshwarane ka mabogo. Le mme o fa re metsi a nwe. O mongwe le o mongwe o filwe se a nosang o mongwe ka sone. Ke gore ro be re eswa re le mmogo, re bolokana. Ke tshwaragano e kgoro le thabologelwe. Ke a kgone go a siame, le kga metsi. Ge ho a tsitoli a sa tshelweng sepe, ba kgone go a tsitoli a seke. Ke gore ro be re eswa re le mmogo, re bolokana. Ke a kgone go a siame, le kga metsi. Ge ho a tsitoli a sa tshelweng sepe, ba kgone go a tsitoli a seke.

INT: E le gore wena tiro e o e kgonang thata-thata, bolwetsi bo o bokgonang thata-thata ke bofe? O rile ke asthma?
RESP: No, no, no! Ke specialaesa thata ka ba bana.
INT: Oooh! Ka malwetsi a bana.
RESP: A bana thata. Le go remela.
INT: Go remela ke go dira eng?
RESP: Ge motho a sa bone tsalo.
INT: Oooh! O thusa ba ba sa tsholeng!
RESP: Le makgome, le serunya. Asthma le yona ke a e alafa, fela sotlwa ke magogwe.
INT: Ehe! Nkgonne, a ke o mpolelele. A go na le malwetsi a mangwe a a itsiweng ke dingaka tsa setswana feela, a makgowa a sa a kgoneng?
RESP: A a sa a kgoneng?
INT: Mmmm!
RESP: Go na le bolwetsi ba bosengwa. Go na le bolwetsi ba seebana. Ne ke lebala bolwetsi ba seebana. Ke a se alafa. Seebana se ga se tle ka tsela e le ngwe. Go na le seebana sa moya. Motho o mongwe o tsenwa ke seebana a na le moya, e le pitso ya Modimo kgotsa pitso ya badimo ba gagwe. Go na le bolwetsi ba seebana, bo e leng ba moleko. Go na le bolwetsi ba seebana bo bongwe, bo e eleng gore ke ba lesika. Ga a tle ka tsela e le ngwe. Bjaanong ke na le seebana se ke se alafang. Go na le seebana se se reng ge se tshwere motho, e be se feleletsa se mo dirile setswana, mme bo simolotse e le seebana. Molwetsi yo ge a ne a sa sha, ke kgonha go mo alafa. Mme le bona bolwetsi bo bo nshokodisa ka gore ke bo alafa ka nonyane.
INT: Mmmm! Nonyane mang? E didiwang?
RESP: Mokgoba.
INT: Mokgoba?
RESP: Eng. Nonyane e;
INT: Nyaa. Ga ke e itse.
RESP: Ka setswana gape ba e bitsa ba are ke Kopaopa.
INT: Oooh! Kopoopo! E na le (o supa ko morago ga tlhogo)...
RESP: Eheee! E ja borekhulu. Ke yone ye e kgonang go alafa diebana tse tsotlhe tsehna kwa ntle ga seebana sa moya. Bjaanong ke sokodiswa ke go thoka nonyane e. Meleme e mengwe e teng, fela e kopangwa le nonyane e. Yona re e alafa ka dinawa tsa setswana, le yona kopaopa o, bjalo.
INT: Bjaanong kopaopa o, o a mo omisa? Ke gore ke go boletsa gore e tle ere ge ke kopane le ene kwa Bopedi kwa, ke go tlele.
RESP: Kopaopa o bjaaka ge o bolailwe, re a o phatlola, re o anege sentle.
INT: O tlosiwa mafofa?
RESP: Mafuka ke ona a tlo bereka ka gore o aramediwa ka mafukana a ona.
INT: Mara a tlositswe mafofa? O a thobile?
RESP: Eng. O a thobile. Maboa ao a thobiwa "seperate". Ga a laatlhiwe othhe a kopaopa. Dinama tse le stona di sa ntse di tlo tsengwa mo go aramediweng. Mafuka ale ke ona a re tlo tla re bofa meleme e mengwe gape ka ona. Re bofa ka mafuka ale. Go apeiwa le ka dinawa tsa setswana,

INT: Ke gore ke botsenwa le seebana!

RESP: Eng. Seebana sena, o mong o simolla e le seebana, se feleletse se kopane le botsenwa. Ge setse se topeletse, se feleletsa se dirile botsenwa.

INT: Mmmm!

RESP: Go na le bolwetsi jwa botsenwa. Ke alafa setsenwa se se nang le moya.

INT: Thalosa.

RESP: Go na le botsenwa. Botsenwa bo ga bo tie ka tsela e le ngwe. Go na le botsenwa bo motho a ka bong a rometswe pholofotswana e ngwe gothwe ke tokoloshe. Ke kgona go bo alafa. Go na le botsenwa bo e leng ba moya. Ge moth a na le moya wa badimo. Motho ge a na le badimo, a tshwengwa ke thomo ya badimo, o na le go tsewa. Motho ge a na le moya wa boporofofetse, wa pitso ya Modimo, o na le go tsewa. Ke malwetsi a ke a lalafang ao. Ke alafa mefuta ya botsenwa ge bo tlile ka tsela tse tse pedi tse. Ge bo tlile ka tsela tse dingwe ga ke bo itse.

INT: Hmm! Nyaa, ke a utlwa. Kgang e ngwe ke e. Puso ya re re tshwanelwa ke go dirisana le ba tsa pholo, re tsee tsela mmogo. O reng ka taba e?

RESP: Nna kgang e ke a e amogela ka gore ke solofela gore ba gabona, le ba ba mo dikokelonga ba bangwe ba a swa. Ga nke the ba a swa, ba lomeletshega. Ba tla kgona go thusiwa. Nna ke a e amogela. Re tshwanetse go ka dirisanya le bona, re thusanye le bona mo makoeng a ba sa a itsing a rona, a thago, a ditso.

INT: O bona le ka dirisanya jang?

RESP: Mo dingakeng tse tsa rona tsa setso tse, go na le ba bangwe ba e reng ge molwetsi a ka tla fa go nna, nna ga ke wa kalafi ya teng; mme ke itse mang-mang a na le kalafi eo. Motho wa mo futa o o ntseng jalo ke mo isa kwa mothong ole o ke itseng a na le kalafi eo.

INT: Wa setso?

RESP: Eng. Wa setso. Ga e ne e le malwetsi a ke itsing a kgonwa ke sekgowa...

INT: Jaaka afe?

RESP: Go na le motho a ka bana le dintho tse di ka fa gare; makgome a a ka fa gare, a a kekerelang ka fa gare fela; kgotsa a thubegetsa kgala ka fa gare. Moo ga ke kgone. Ke solofela gore ge motho a thubegetsa kgala ka fa gare, ke malwetsi a a kgonwang ke sekgowa. Ge motho a na le ntho e leng teng ka fa gare, e o bonang gore e atamile, e ka se kgonwe ke kalafi ya setswana, ke motho
yo a tshwanetseng a ye kwa sekgoweng. Re na le motho e tle e re a tshabile le o mong ka thipa, a ba a tla ngakeng ya setswana. A tshabile ke o mong ka thipa! O ke o ke sa mo amogeleng ka gore ga ke itse sepe ka madi le go roka. Ngwana wa phogwana ge a lathegetswe ke metsi a le mantsi ke mo romela kwa kliniking gore a tsengwe dripi. Tota nna nka rata go berekisana le ba kliniki kgotsa le bona ba spatala ge ba nthometse motho fo nna. Di tsa rona tsa setswana di na le meila.

**INT:** Meila?

**RESP:** Eng. Go na le dikalafi tse dingwe tse di batlang meorametso. Bjaanong ke dilo tse di batlang motho a berekela a le fa gae. Re berekisa dikgong tsa rona tsa setswana. Re berekisa mangetane (dinkgwana tsela tsa kgale). Ke dingwe tse di batlang o berekela fa gae ka di na le meila.

**INT:** Mmmm! Ke utlile nkgonne. Ga ke dumele gore go sa ntse go thokega gape. Ke a leboga mma.
Research Question: Explain to me what the contributions of indigenous healers are to health care.

RESP: We indigenous Setswana doctors we help in cultural treatment. I start first with the child. After birth of the child preventive treatment is started by preparing *ditanyane*. The *ditanyane* I am talking about are prevention of umbilical colic to relax the internal sinews of the child.

Once that is complete there is prevention of diseases to immunizes like the disease of *Tlhogwana*. Once the disease has infected the child the child starts to have diarrhoea. Water diminishes from its body. If it is severe the skin becomes wrinkled and adherent like that. Now we immunize it by inhalation of children's medicines. We also smear them (medicines) on it.

The inhaled medicines prevent *tlhogwana*. If this child is already affected by *tlhogwana* before immunization there is inhalation specifically for an already affected child. Mothers, more often children get *tlhogwana* when they start teething. This is when the sinews start to stretch resulting in sunken fontanelle. It sinks. The child *thuba* sssssss.

INT: To *thuba* is to vomit?

RESP: Yes. It has diarrhoea down as well as vomiting up.

INT: Mmm!

RESP: This child will have mucous diarrhoea mixed with green. Then the diarrhoea stools become grey and then diarrhoea becomes watery. This is when *tlhogwana* has set in. In that case too there are inhalations for that. Especially me really, with children I specialize mainly in children.

INT: You are child specialist!

RESP: With children mostly, with children.

INT: Mmm!

RESP: There is another disease of children that opens up the anus.

INT: What is it called?

RESP: We call it *kokwana*.

INT: Okay.

RESP: Yes. This *kokwana* is not localized to one place. The one that readily opens up the anus of the child is the one that is present in the vertebral column. If it is in the vertebral column, the child suffers from back ache, delays to walk. Its back has no power. It too is another disease that is treated. This *kokwana*, in another it stays in the abdomen. If it is in the abdomen, the child looses appetite and vomits incessantly. This *kokwana* disease is a communicable disease among children. It means it is infectious.

INT: Ooh! It is infectious.
RESP: Yes. It has a tendency of being infectious.
INT: Where did the child pick it up from?
RESP: It is when a child comes into contact with another child who has recently suffered from this disease and who has just finish the treatment; without having given days for not coming into contact with other children there is the possibility of infection. Now, when the child has this disease it must be treated so that it must not become heaver than other children; to be heaver than others when we say go okama. Yes. It is to be heaver than others. If you do not work it in that manner it is possible that the next child he/she meets becomes infected. It is passed on to the other.
INT: Nothing having been done to this other child?
RESP: The one on whom nothing was done! If you do nothing so that he/she does not become heaver than other. Now we work it in this manner so that she/he does not become heaver than others. We use its own hair and its nails. We mix with medicines that treat this disease. The child is capable of cure.

There is another prevention for children when they start teething in the mouth. They begin to be very ill. It is the time when they are predisposed to diseases. There are preventive measures that we put on the children to dress these children so that when it starts to teeth it should teeth easily and not be attacked by diarrhoea and vomiting.
INT: Mmmm!
RESP: It can so happen that this child starts, perhaps when it is born, it is born with a disease we call makgome. These makgome diseases I treat a lot.

INT: Makgome?
RESP: Yes, makgome. Sometimes we call it seroma. The child can develop sores even on the head. Develop severe sores that look frightening throughout the whole body that even ooze fluid. Hair begins to fall off. Such a child is affected by makgome. Usually such a child had contacted the disease from the parent’s uterus.
INT: From the uterus of the mother?
RESP: Yes. The mother having had these sores we call makgome. This makgome is caused by the fact that a woman miscarries and never gets Setswana boiled medicines to drink until she conceives on the dirt. The child will have makgome. This makgome is capable of causing asthma.
INT: Ooooh!
RESP: It blocks the lungs of the child when it (makgome) is inside like this. It comes out; when it is outside it is treated by go forolwa.
INT: By the way what do you mean by go forolwa? Do you mean smearing on the body?
RESP: Yes. Yes. With medicine. It is applied very early in the morning. It is treated very early in the morning. It is not treated any time. In the morning before anything is taken orally, nothing, nothing, nothing.

INT: Mmmm!

RESP: Before sunrise, at dawn. It (the baby) is faced East. It is smeared and then given oral medicine to drink. It becomes cured quickly, quickly. It is not a difficult disease. When it affects it, it affects it even between the toes. The child peels off. The sores ooze fluid and become purulent. This is the disease of makgome. It is diseases that I able to cure, of children; that I treat. I talk of those I treat.

INT: Now, when we come onto the women?

RESP: Women? On the side of women we assist women who not lucky to conceive. Those who do not bear children. This women I help very much. There are women who do not conceive due to a disease we call sekaka (boil) inside. That means if this "boil" is in this women, this one who does not conceive, sometimes she has a fleshy part in the anal area. It looks like flesh; it looks like a sore. This person who has a boil usually does not conceive. Even if she can conceive by luck, they die.

INT: Mmmm!

RESP: This boil has its treatment. We excise this boil very early in the morning and apply its medicinal treatment. She is also given medicines that cleanses the abdomen. She is also given medicine called moremela.

Another one may not conceive due her eggs not being fertile. The difference lies in what you saw during examination that makes her not to conceive. They are not the same. If her eggs are not fertile there is a medicine that she is given that she takes with milk. This one strengthens her fertiliser so that she can have a seed which must germinate. It is meremela. These meremela are different. One may not conceive due to the disease we call makgome. It also prevents conception.

INT: Makgome?

RESP: Yes. The very makgome. She must be treated for this makgome, her internals be cleansed with medicines and also be given medicine we call moremela that will prepare the uterus. The other will not bear because the mouth of her uterus stands on the side.

INT: It means the mouth of the uterus?

RESP: Yes. If it stands on the side it becomes too affected by air. We massage this person and give her medicines that rectify the uterus while the uterus is being massaged. We massage it so that it can return to the normal position. After it is massaged and has returned to the normal position the person is able to conceive.
There are diseases that I come across in which makgome are present in a woman. You find their genitals full of sores even underneath. They also ooze water. The person with this disease is also treated by local applications, is given medicines and those that she should drink. This disease is curable. There is among women where their fruits don’t function. The woman does not have the desire.

INT: You mean she does not have the desire for a man?
RESP: Yes. She does not have the desire where it does not work totally, totally, totally at all. Where she is dead. There is medicine that we give her. The medicines that I use are taken with milk. They are what we call “sharpeners”. We are sharpening. These we prepare with bommabatsane. Yes. And thorns. We sharpen this person to become all right.

INT: Until she develops the desire?
RESP: Until she develops the desire. There are women’s diseases where a person may not conceive due to the Setswana malice. Those with malicious intentions have done so due to jealousy, which term witchcraft. It will happen that during divination the cause of all this will show. Even in this one has its own treatment. These treatments are not the same. It depends how the disease came about and is treated with a particular medicine. Such a person is also able to be treated to end this malice until she is able to get children. There is such (I am through with women) on the side of men. Men are prone to sexually transmitted diseases which I call “drop” or khutlego.

INT: Which you call what, drop?
RESP: Yes. Khutlego.. In Setswana we call it khutlego. This khutlego takes various forms. It too is not the same. There is another type which when a person has sexual intercourse with a person who is widowed will get khutlego; the person having not received treatment. When a person has contacted this one we call it seswagadi (widowhood).

INT: Oooh. Boswagadi!
RESP: Boswagadi. Now this boswagadi ends up causing khutlego in the man. This disease finishes the man up. It softens his weapons of manhood. These weapons become smooth and work no more. It then becomes necessary that this man be treated with the sharpness finally being prepared for him. This man becomes healthy and well.

There is another disease of men in which his eggs for fertility have no fertilizers. The treatment is the same as that of women.

INT: Mmmm! It means this man will never make children?
RESP: He does not make children. His seed is watery. It becomes strengthened. There is also this disease of khutlego that ends up causing a kidney disease. This khutlego that destroys the kidney is very dangerous. Very, very dangerous. His bladder controls itself; the urine just flows freely. It is incontrollable. He does not even feel that he wants to pass water. It is khutlego that has
already destroyed the kidneys. It too is treatable but it takes longer to help a person with kidney problems because that take time. It is because they will already developed sores from within, already being unable to sift water well, to convert water into urine; to sift properly. When these kidneys are destroyed a person urinates yellow mucous and greenish smelly stuff. It controls itself; that is, after the free passage of the water what follows is this mucous-like substance that looks like pus. It is when it has weakened the kidneys. And when it has affected them there is back ache. The person is unable to bend. It affects the sinews which become affected by cramps. This disease is also treatable. These are the ones that I treat.

There is another disease among the people called _serunya_. A person with this disease develops a sore here and when it is supposed to heal it develops there and moves to here, until it penetrates the bone.

INT: Mmmm!
RESP: This disease among the Europeans a person ends up being amputated.
INT: What do the Europeans call it?
RESP: I do not know what they call it. I know it in Setswana. This disease is treatable. A person with disease can develop worms being alive. It is a disease that I treat, this _serunya_.
INT: Do you treat it with a mole?
RESP: No, no. I do not treat it with a mole. Actually _serunya_ has its medicines that I treat it with. The mole too is added. But there is one that prevents it from spreading. You confine it. You tie it so that it stays at the same place so that the disease does not travel through the whole body. Once you have confined it like that then you start to cleanse it and pour its medicines. This disease is curable. If it had already penetrated through the bone then we treat it with _meomo_ of animals.
INT: What is _meomo_?
RESP: Bones of animals. When you pour you start by pouring on this bone so that it can be welded together. It must be welded by other bones of animals. Then you start to treat the skin, the wound and muscles.
INT: Mmmm!
RESP: There is the disease of asthma. I treat asthma but it is difficult. The medicine that I use for treatment which is not dug is of another animal that eats honey.
INT: What is it?
RESP: _Magogwe_.
INT: _Magogwe_?
RESP: Now I find difficulty in finding _magogwe_. Those that I have treated I have treated. But I have stopped because _magogwe_ is finished. It is _magogwe_ that makes it difficult for me. It is curable.
INT: What do you need from _magogwe_?
RESP: The bones.
INT: Do need the bones only?
RESP: I treat with the bones because it is the bones that are full of honey. They are full of honey. You treat the marrow that is full of honey and bones that are built of honey.
INT: Mmmm!
RESP: It is the bones that are able to treat asthma.
INT: Do you drink or are incised?
RESP: You drink. Yes. You are given to drink. It is asthma that I treat. But I am given difficulties by magogwe. Other medicines are available, it runs short of magogwe.

There are diseases that are found within families; here there is no peace in the family due to the malice of a person. They can be cured, those that are caused by the malice of a person. There are family problems where you find no peace in the family. If they are due to malicious deeds of a person they are capable of being stopped.

There are family problems created by the lack of trust and dishonesty. The other party goes out. When he/she has found a partner outside the other partners start to be jealous. He/she starts to cause malice in the family wanting to be loved by preparing love potions for him/her.

INT: So that she/he can be the only one loved?
RESP: Yes. It is one thing that is possible so that when the other partner comes home he/she just gets annoyed. It is possible that such a person be helped by being given medicines that makes something to rot. I do not give an emetic to remove it. I don’t let a person vomit because some dijese are of live creatures! They come out with flesh and blood. I usually make the trouble rot so that it could come out down here. It is easier that way. It does not exhaust a person. It is not dangerous. But it is a slow process.

INT: It takes time!
RESP: It takes a little bit of time. It is not as fast as in those who induce vomiting. I do not induce vomiting. I let it rot so that a person can remove it from underneath and not be inconvenienced but be able to work. He/she should not be bothered by anything but should feel energetic. When that thing is out you are able to give him/her medicine called tshedimogo so that he/she can start to realize who he/she is. It is possible that he/she can be all right. It is possible that she/he can be all right, the family be rebuilt and fine and they become protected.

In Setswana culture we have people who start their marriage. People in our culture when they start to marry, they are tied together culturally so that nothing should come in between these people that will end up causing divorce. There is medicine that they are treated with. They are treated holding hands when we strengthen this marriage. Now culturally we use scarification. I use scarification with them holding hands. After finishing I draw water. The husband gives his...
wife to drink, water wherein nothing is added, while they are still holding hands. The wife too gives the husband water to drink. Each one is given something for giving the other water to drink with. It means we will die together and bury each other. This is the biggest bringing together. In life people are not brought together when they marry and are not protected the cultural way usually there are interferences among them. One is unable to withstand the difficulties of the other because they have not been brought together culturally. But once they have been brought together culturally the one is not impatient towards the other. When one encounters difficulties the other supports him/her until they overcome these difficulties. This, this is what I am able to do.

In the family. A plot is treated if people must stay in it. It is prevented here, unwanted incidences and that they must not be made mentally deficient within this family. So that when they work they should cooperate within the family and progress. This family is treated to prevent outside things from intruding. This is prevention. When we say we fortify a home this one activity I perform.

INT: Oooh! In children’s diseases.
RESP: Of children mostly. And to enable women to fall pregnant.
INT: Go remela is to do what!
RESP: When a person does not bear children.
INT: Oooh! You help those who do not bear!
RESP: And makgone and sesunya. I also treat asthma, but my problem is magogwe.
INT: Is that so! Now sister, tell me. Are there any diseases that are known to indigenous healers only, that are unable to be treated by Europeans?
RESP: Those that they are unable to treat?
INT: Mmmm!
RESP: There is mental illness. There is epilepsy. I forgot epilepsy. I treat it. Epilepsy does not present in the same way. There epilepsy of the spirit. A person gets epilepsy because he/she has the spirit, being a calling from God or from his/her ancestors. There is epilepsy caused by witchcraft. There is another type of epilepsy which is familial. They do no present in the same ways. Now these types of epilepsy I treat. There is the type of epilepsy which when it affects a person he/she ends up mentally ill, but being epilepsy. If this patient is not burnt I am able to treat. This disease too poses problems to me because I treat it with a bird.
INT: Mmmm! What bird? What is it called?
RESP: Mokgoba.
INT: Mokgoba!
RESP: Yes. This bird.
INT: No. I do not know it.
RESP: In Setswana it is called Kopaopa (Hammer Bird).

INT: Oooh! Kopaopa. It has (points at the back of the head) ....

RESP: Yeess! It eats gum. It is able to treat all epilepsies except epilepsy of the spirit. My problem is the inability to find this bird. We treat it with cultural Setswana beans and this bird like that.

INT: Do you dry this bird? I am asking you so that if I come across it in Bopedi I could bring it with for you.

RESP: When this kopaopa is killed it is broken and dried well.

INT: Do you remove the feathers?

RESP: The feathers are the ones that are going to be used for inhalation.

INT: But you remove the feathers?

RESP: Yes. You remove them. The feathers are removed separately. They are not to be thrown away. The flesh too will be added to the inhalation. The feathers will be used to tie-up other medicines with. And we cook Setswana beans, and this person becomes healed and lives. The person does not drink a lot of treatment. He/she is treated by inhalation. At the end of the inhalation we grind that medicine, she/he sniffs it through the ear and nose alternatively like that. That medicine is also cooked with Setswana beans. This disease we throw into an ant-hole. He/she does not drink its treatment repeatedly. He/she eats it sometimes and he/she is healed. In the morning it is thrown away and it's finished. It is another disease that I nearly forgot. These are the ones that Europeans are unable to treat.

INT: It means it is mental illness and epilepsy.

RESP: Yes. This epilepsy. One starts with epilepsy and ends up being mentally ill.

INT: Mmmm!

RESP: There is mental illness. I treat a mentally ill person who has a spirit.

INT: Explain.

RESP: There is madness. This madness does not occur in the same way. There is mental illness where a person could have been sent a small animal called tokolosi. I can treat that. There is mental illness caused by a spirit. When a person has a spirit of the ancestors. When a person has the spirit of prophesy, of the call of God, she/he can be mentally ill. These are diseases I treat. I treat the kinds of mental illness if they develop in these two ways. If they develop in another way I do not know it.

INT: Mmm! No, I here. Here is another matter. The government states that we should work with those of health, and work together. What is your opinion about this?

RESP: I accept the news because I am certain that our people and those in the hospital, some die. They will no longer die disadvantaged. They will be able to be helped. I accept. We should cooperate
with them, help each other in relation to our conditions that they do not know, the natural cultural ones.

INT: How do you see yourselves working together?

RESP: Among our indigenous healers there are those that will come to me and I do not have the treatment, but I know this one and that one who have. I take such a person to the one who has such treatment.

INT: An indigenous one?

RESP: Yes. An indigenous one. If its diseases that I know could be treated by Europeans ....

INT: Like which?

RESP: A person can have internal sores that spread within or when bile has broken inside. There I am unable. I believe if bile has broken inside these are diseases that Europeans treat effectively. If a person has a wound internally that seems to have spread it cannot be cured by cultural treatment. Such a person should go to Europeans. We have people who are stabbed with a knife and comes to an indigenous healer. Stabbed by a knife! That one I will never accept because I do not know anything about blood or suturing. A child with phogwana who has lost a lot of fluid I send to the clinic for a drip to be put up. Actually I would like to work with clinic personnel and with hospital personnel if they send a person to me. Our cultural things have taboos.

INT: Taboos?

RESP: Yes. There are certain kinds of treatments that need inhalations. These are things that needs one to operate from home. We use our cultural wood. We use broken earthenware pots. These are some of the things that need us to operate from home because there are taboos attached to them.

INT: Mmmm! I have heard older one. I do not think there is anything more. I am grateful, Mama.
Annexure 6

Permission to Conduct Research
17 August 1994

ATTENTION: SOPHIE MAHOKO

University of Bophuthatswana
Department of Nursing Science
Private Bag X2046
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The Academic and Accreditation Committee wishes you well on this project.

We are encouraging you to go ahead, and to call on us whenever you need our assistance.

Yours sincerely,

DR T.E. RANGAKA
DIRECTOR OF HEALTH SERVICES
(101/94)

SN Shai-Mahoko: The Role of Indigenous Healers in Disease Prevention... Annexures: p.198
Annexure 7:

Cleansing Ritual — A Case of Spirit Separation
Annexure 7:
Cleansing Ritual: A Case of Spirit Separation

History

Thirty year old Mrs S is a Sangoma and had been ill for months. She came to a healer accompanied by her elder sister and a friend. The highest qualification of Mrs S’s sister was a Masters degree. Mrs S left school when she was sixteen years old to become a healer.

On Divination

Mrs S is told that she is possessed by the ancestral spirits of her maternal and paternal parents; and that her illness was brought about by the two spirits fighting for her within her. She, as the victim, formed the battleground for the two spirits she was told. The solution was to separate the two spirits by a cleansing ritual so that only her maternal spirit could remain with her. Mrs S agreed to be subject to the treatment.

The Ritual

Mrs S was instructed to bring all healing paraphernalia that belonged to or was given to her from her paternal side. The only things that she was given from her parental side were four diving bones. On her maternal side she was shown and given a Bible which she brought with her.

The separation ritual took place in the open veld. Mrs S was instructed to bring a black hen for purposes of cleansing. A hole was dug at the foot of a tree. Mrs S was instructed to pour snuff in the hole and asked to tell her ancestors that she needed to separate the two spirits because they made her ill and that she wanted to be healthy again in order to go on with her healing work. This was done and in the process Mrs S started to cry. A black hen was made to drink a medicinal mixture. Next, Mrs S undressed and was washed with the same solution. The hen’s head was cut with a brand new knife. Its dripping blood was allowed to flow over Mrs S as the healer slowly and carefully moved it over the head, shoulders, arms, abdomen and back of Mrs S. The medicinal solution was again used to wash Mrs S using a flail; and Mrs S was instructed to sit about four metres away and never look back until she was inside the house of the healer. The gizzard was taken out and the four diving bones were put in it and hung on the tree and left there.

Meanwhile she was instructed to sit about four metres away. The hen was garnished with medicinal herbs and roasted on an open fire. With hands at the back Mrs S was given the first piece of the roasted chicken in the mouth by the healer (see Figure 12). The bones of the chicken were buried in the previously-dug hole together with the head of the chicken.

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Annexures : p.200
Mrs S then went home without looking back. Those who were with Mrs S were also sprinkled with the medicinal solution that was used on Mrs S and were told not to look back.

On arrival at the healers house Mrs S went into a trance and started to talk in a changed voice. She said, "I greet you, you ...... (name of the healer who cleansed her). I thank you. I ........ (name of the ancestral spirit in her) am now going and will never come back". In turn the cleansing healer, now in a trance, said, "When you go home tell your paternal uncle to slaughter a white goat for you, to accept the one who is now remaining in you. A little beer will form part of the ceremony. Everything will be well. Go well and bring us rain and health.

When Mrs S came to she did not know what happened or what was said to her. Her sister explained everything to her.

Mrs S was incised in all joints, back and sternum; and a blacking oily medicine stored in a horn (See Figure 12) was rubbed into the incisions. A dry mixture of herbs was then put on burnt coal so that is smoked. Mrs S was then covered with a blanket to inhale the smoke. The ritual ended.

Follow Up

Six months later Mrs S had joined the St John's Apostolic Church. She had not relinquished divination but she does not sing and dance any more as a Sangoma. She reported she was healed and had gained weight.

SN Shai-Mahoko : The Role of Indigenous Healers in Disease Prevention ... Annexures : p.201
Figure 13: Horn Used by Healer to Store Medicines
Annexure 8:

List of Medicinal Plants Found in the Gardens of Indigenous Healers and Their Usage
## Annexure 8

**List of Medicinal Plants Found in the Gardens of Indigenous Healers and Their Usage**

<table>
<thead>
<tr>
<th>NAME</th>
<th>USE</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Sengaparile</em> (Kalahari Devil’s Claws)</td>
<td>• Reduces high blood pressure</td>
</tr>
</tbody>
</table>
| *Konofolo* (Garlic) and *Aie* (onion) | • Builds resistance against severe colds and flues  
• Reduces high blood pressure  
• Used as food |
| *Parsell* (parsley) (eaten raw) | • Used effectively for colds                                         |
| *Lengana* (wild all) | • Reduces temperature (fever)  
• Used as tea for colds and flues  
• Given as enema for fever constipation in children |
| *Benereiti* | • Used as tea for colds and flues                                    |
| *Sage* | • Used as tea for sore throat  
• Used by lactating mothers to dry up breast milk to wean the child off |
| *Kgomo-di-metsing* (mint) | • Anti-arthritic                                                     |
| *Torokofeie* (prickly pear) | • Top layer peeled off, soaked in cold water; juice taken three times a day to treat diabetes mellitus |
| *Makgonatsotlhe* (camomile) | • (As tea) to treat wounds, prevent infections, prevent arthritic pain  
• To calm patients and induce sleep |
| *Mathuba-difala* | Boiled and drunk as tea  
Purifies blood |