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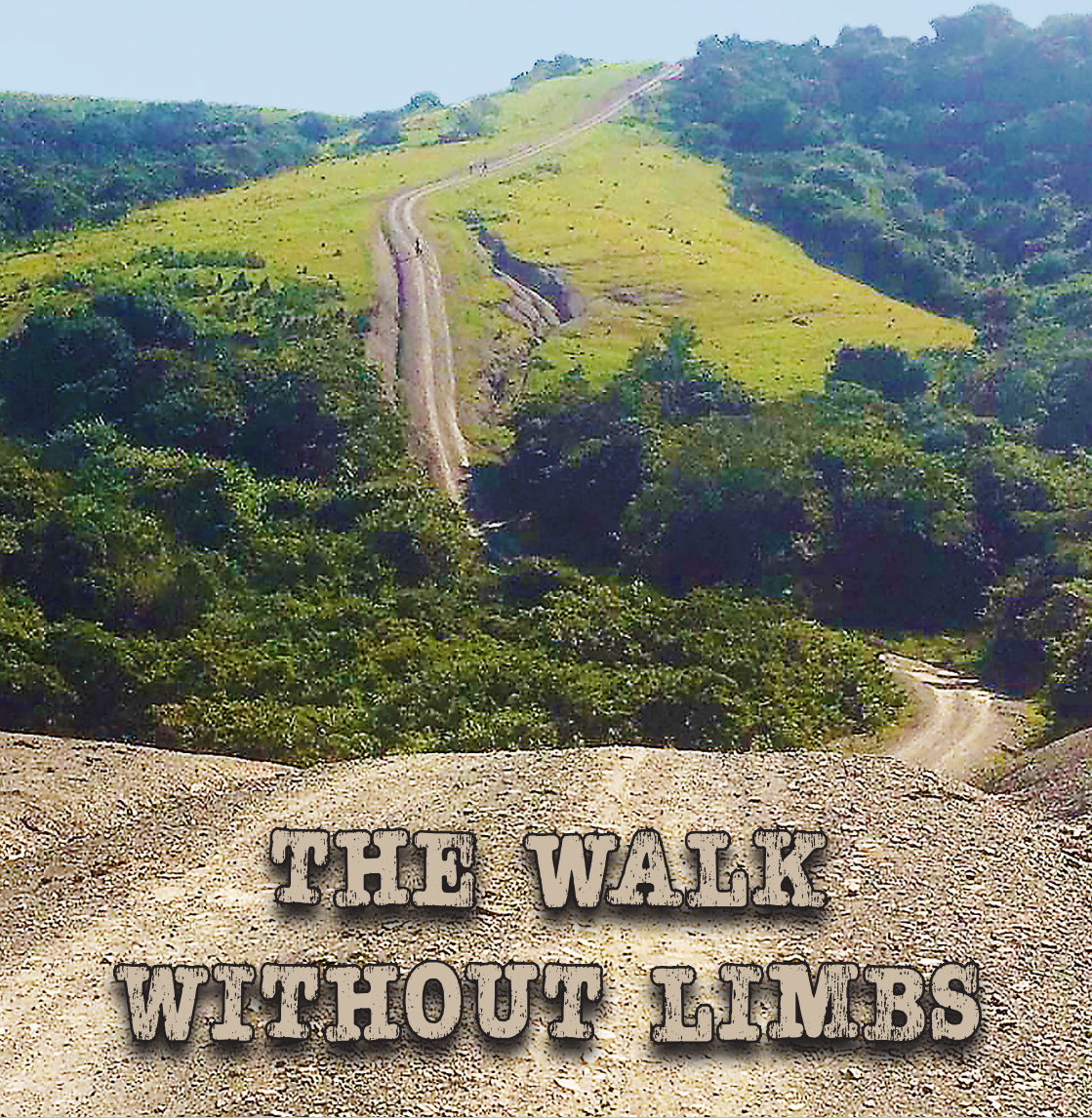
Searching for Indigenous Health Knowledge
in a Rural Context of South Africa



THE WALK WITHOUT LIMBS

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Searching for Indigenous Health Knowledge in a Rural Context in South Africa

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THE WALK WITHOUT LIMBS

Searching for Indigenous Health Knowledge in a Rural Context in South Africa

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AOSIS

Peer review declaration

The publisher (AOSIS) endorses the South African 'National Scholarly Book Publishers Forum Best Practice for Peer Review of Scholarly Books'. The manuscript was subjected to a rigorous two-step peer review process prior to publication, with the identities of the reviewers not revealed to the author(s). The reviewers were independent of the publisher and/or authors in question. The reviewers commented positively on the scholarly merits of the manuscript and recommended that the manuscript should be published. Where the reviewers recommended revision and/or improvements to the manuscript, the authors responded adequately to such recommendations.

Research Justification

In a country as diverse as South Africa, sickness and health often mean different things to different people so much so that the different definitions of health and health belief models in the country seem to have a profound influence on the health-seeking behaviour of the people who are part of a vibrant multicultural society. This book is concerned with the integration of indigenous health knowledge (IHK) into the current Western-oriented primary health care (PHC) model. The first section of the book highlights the challenges of training health professionals using a curriculum that does not draw its knowledge base from a certain context and the people of that context. Such professionals will in due course realise that they are walking without limbs on health matters. *KwaBomvana* in Xhora (Elliotdale), Eastern Cape province, in rural South Africa, inhabited by the *Bomvana* people (also called the *AmaBomvana*), was chosen for conducting this study. This area is served by the Madwaleni Hospital and eight surrounding clinics. Qualitative, ethnographic, feminist methods of data collection support the research conducted for Section 1 of the book. Section 2 comprises translation and implementation of PhD outcomes and had chapter contributions from other researchers as well. In the critical research findings of the PhD study, older Xhosa women suggested the inclusion of social determinants of health as key to health problems that they managed within their homes. For them, each disease is linked to a social determinant of health, and the management of health problems includes the management of social determinants of health. For them, it is about the health of the home and not just about the management of disease. They believe that healthy homes create healthy villages, and that the prevention of disease is essential for strengthening of the home. Health and illness should be seen within a physical and a spiritual context, and without health, there can be no progress in the home. When defining health, the older Xhosa women added three crucial components to the definition of health by the World Health Organization (WHO), namely, food security, healthy children and families, and peace and security in their villages. Mji further proposes that the above-mentioned three elements should be included in the next revision of the WHO health definition because they are not only important for the *Bomvana* people where the research was conducted but also for the rest of humanity. In the light of the promise of National Health Insurance and revitalisation of the PHC, this book proposes that these two major national health policies should take cognisance of the IHK utilised by the older Xhosa women. In addition to what this research implies, these policies should also take note of all IHK practised by the indigenous peoples of South Africa, Africa and the rest of the world, and that there should be a clear plan as to how this knowledge is to be supported within a healthcare systems approach. The target audience of this book are academic educators, students mainly from the health sciences domain, professionals and policymakers. This book contains original research and no part of the book has been plagiarised. I also declare that this book has not been submitted to any other publisher for publication.

Gubela Mji, Centre for Rehabilitation Studies, Faculty of Medicine and Health Sciences, Stellenbosch University, Cape Town, South Africa.

Contents

Section 2: Translation and application of PhD critical research findings on the research site: The backward and forward movement – Trying to find our limbs

Abbreviations, Boxes, Figures and Tables Appearing in the Text

List of Abbreviations

ABCD	Asset-based and Community-driven
AIKS	African Indigenous Knowledge Systems
ANC	African National Congress
CBR	Community-based Rehabilitation
CDRA	Community Development Resource Association
CHCs	Community Health Centres
CNPs	Clinical Nurse Practitioners
DFID	Department for International Development
DHET	Department of Higher Education and Training
DRC	Democratic Republic of Congo
DWF	Donald Woods Foundation
EBF	Exclusive Breast Feeding
EC	Early Childhood
ECD	Early Childhood Development
FG	Focus Group
FGDs	Focus Group Discussions
FNB	First National Bank
FRCs	Financial Resource Centres
GMO	Genetically Modified Organisms
GP	General Practitioner
ICF	International Classification of Disability and Health
ID	Identity Document
IDP	Integrated Development Plans
IGIs	Income-generating Initiatives
IHK	Indigenous Health Knowledge
IHRO	Indigenous Health Research Outcomes

IKS	Indigenous Knowledge Systems
KABP	Knowledge, Attitudes, Beliefs and Practices
LM	Local Municipality
MFHS	Medical Faculty of Health Sciences
MHAs	Minor Health Ailments
NGOs	Non-governmental Organisations
NHI	National Health Insurance
NRF	National Research Foundation
OTCs	Opportunistic Transitional Conversers
PC	Primary Care
PHC	Primary Healthcare
PHCS	Public Healthcare System
RDP	Rural Development Plan
RUDAR	Rural Development and Agrarian Reform
SALDRU	Southern Africa Labour and Development Research Unit
SCGs	Savings and Credit Groups
SDG	Sustainable Development Goals
SICG	Savings, Investments And Credit Groups
SIGs	Savings and Investment Groups
SLA	Sustainable Livelihood Approach
SLCA	Sustainable Livelihoods and Capabilities Approach
SLF	Sustainable Livelihood Framework
SUN	Stellenbosch University
TATU	Transkei Appropriate Technology Unit
TOC	Transitional Opportunistic Conversers
UCT	University of Cape Town
URC	University Research Committee
VIPs	Ventilated Improved Pit Latrines

List of Boxes

List of Figures

List of Tables

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Gubela Mji is an associate professor at Stellenbosch University and the director of the Centre for Rehabilitation Studies. She also chairs the African Network for Evidence-to-Action in Disability (AfriNEAD) and is the president of the Association for the Physically Disabled for the Cape Town region. She has published academic papers in leading journals and chapters in books of leading publishers. She has delivered keynote presentations at prestigious regional and international conferences. She has been invited to participate in dialogue and decision-making by leading national, regional and international decision-makers in the development of indigenous, international and global health and rehabilitation frameworks. Her PhD study in family medicine is based on indigenous health knowledge.

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Karen Galloway currently lives on a small-scale farm in the Eastern Cape, and has a passion for rural rehabilitation, health advocacy and transitioning from hospital to home. She has a BSc degree in physiotherapy and a BA degree with community development as her major. She has published a paper on the early identification of tuberculosis in the spine.

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Lieketseng Ned graduated as an occupational therapist (BSc OT, UWC) in 2009 and completed her MPhil in Disability Studies at the University of Cape Town in 2013. She is a lecturer at the Centre for Rehabilitation Studies, Department of Global Health, Stellenbosch University and recently completed her PhD focussing on reconnecting with indigenous knowledge within the current education system: Exploring possibilities for better health and well-being.

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Ntombekhaya Tshabalala grew up in the Eastern Cape, where, early in life, social challenges shaped her career path and the person she has become. She studied social sciences, housing development and management, and obtained a PhD in Disability Studies. Through the support received during her postdoctoral fellowship at the University of Cape Town, and later on at Stellenbosch University, she began her current work with savings groups in various villages in the Eastern Cape province, South Africa. Her long-term goal is the establishment of Financial Resource Centres, promoting community collaboration and solidarity using the values of *Ubuntu* as a basis to regenerate wealth and morality.

Declaration

This book, entitled *The Walk Without Limbs: Searching for Indigenous Health Knowledge in a Rural Context of South Africa*, presents critical research findings that emerged from Professor Gubela Mji's doctoral (PhD) thesis, 'Exploring the health knowledge carried by older Xhosa women in their home situation: With focus on indigenous knowledge systems', which was submitted to the University of Stellenbosch in 2013. A majority of the references cited in this section/chapter(s) are also drawn from Professor Mji's PhD thesis. The book represents a reworking of more than 55% of the original thesis to meet the standards of the publisher and the Department of Higher Education and Training (DHET). No part of the book has been plagiarised or published elsewhere. It is her own work in conception and execution, and all the relevant sources that she has used or quoted have been indicated and acknowledged by means of complete references.

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Introduction

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Critical questions have been raised about the overcrowding of primary care (PC) services, such as community health centres (CHCs) and clinics in predominantly Xhosa-occupied areas in the Western and Eastern Cape provinces, with patients who present with minor health ailments (MHAs).

Suggestions have been made about the integration and use of IHK by the older Xhosa women in these services as a strategy for managing MHAs, and as a way of encouraging appropriate health-seeking behaviour. Preliminary studies have reinforced the need for the revival of IHK, which is currently dormant within communities.

These studies affirm that such knowledge could be an asset if acknowledged by the Western biomedical model, and it could play a major role in alleviating the problem of overcrowding in PC services. Mji[1] explored the health knowledge practised by the

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older Xhosa women in their home situation, with special focus on IHK amongst the *AmaBomvana* people, an indigenous group of people situated in the Mbhashe municipality in Elliotdale. The primary aim of this book is to present, firstly, critical research findings that emerged from Mji's[1] PhD study and, secondly, share how these critical research findings and recommendations were implemented through extended research work that includes other studies, of which three are PhD studies.

The first chapter of this book presents the evolution of this study, providing a status of access to primary health services in peri-urban areas of Cape Town, specifically Khayelitsha. After 1994, universities in South Africa, as part of a transformation agenda, made a commitment and pledged solidarity with disadvantaged communities, this including the placement of students in these communities as part of service learning. Clinical students from rehabilitation and medical departments from one of the nearby universities, who had previously not been placed in peri-urban areas such as Khayelitsha, and their facilitators were placed in these communities where CHCs were overcrowded with patients. Like all public health systems in South Africa, there was a sense of confusion regarding how these CHCs were run, as daily congestion was the order of the day. This was an eye-opener for students who were used to more organised health systems in urban areas.

As clinical student facilitators working in public health care services, we responded to the overcrowding of these CHCs by facilitating fourth-year medical students in initiating mini-epidemiological studies to understand the illnesses that were blighting the patients that were overcrowding the CHCs. Around 24%–25% of these patients appeared to be struggling with MHAs. Minor health ailments are difficult to define, as what might appear minor today, may manifest as a major health problem tomorrow.

The problem of overcrowding of CHCs with patients with MHAs was taken to community health forums that constitute health professionals, Khayelitsha community members and the

elders of this community. The perception of the community elders was that the problem required a deeper investigation as to why persons with MHAs were visiting the CHCs for care and whether there were any community-based health resources, such as IHK, to deal with MHAs at home. This process resulted in two Master's students embarking on research, funded by the National Research Foundation (NRF), with one student exploring the MHAs that were presented by people visiting the CHCs, including the health-seeking behaviour of these persons, and the other exploring the IHK used by the older people in the management of MHAs in Khayelitsha. Results from the Master's thesis exploring MHAs pointed to a deeper underlying problem of failure of implementation of PHC in addressing social determinants of health, including health promotion and disease prevention. The thesis exploring the IHK practised by the older people from Khayelitsha pointed to the need to further explore this IHK in its place of origin, that is, the Eastern Cape province. The older people that were part of this study hailed from the Eastern Cape province before moving to the households of their children in Khayelitsha, and they were faced with restraints in implementing what they considered to be their vocation, which is to look after the health of the home, as the households they were staying in were not theirs. Also, the scarcity of herbs in Khayelitsha that they used in the management of health problems (as they saw that management of the health of the home was broader than management of MHA) in the Eastern Cape province further endorsed for this knowledge to be explored in its place of origin: the Eastern Cape province.

This resulted in Mji[1] exploring the health knowledge practised by the older Xhosa women in their homes, with special focus on IHK amongst the *AmaBomvana* people, an indigenous group of people situated in Mbhashe municipality in Elliotdale (Xhora); this place will later be called KwaBomvane or Madwaleni because of the secondary hospital that is embedded in this area. From the initial interactions with participants and key informants in the research site during community entry, it became clear to the

researcher that the template regarding her research methodology would need to be adjusted. She needed to hand over the research question to key informants and participants who were the knowledge holders of this area. During community entry and checking of the rigour of the methodology, the older Xhosa women, similar to the older women in Khayelitsha, claimed the monitoring of the health of the home as their domain whereby they were involved in a myriad of activities to ensure that balance was maintained. The chief of this area and his chieftain were pointing fingers at foreign entries that they perceived had overlooked their prior knowledge in the areas of health, education and religion, and this according to them had brought upon ill-health to their villages. They said to the researcher, 'you cannot describe what contributes to health without looking at the other side of the coin, that is, what causes sickness', and according to both the participants and the key informants, the main causes for sickness in their area were social determinants of health, particularly poverty.

This reminded the researcher of public health specialists who claim that:

> Health is created in the context of everyday life where people live, love, work and play. Failing to meet the fundamental human needs of autonomy, empowerment and human freedom is a potent cause of ill health. Health is not only a state of well-being as the WHO definition of 1948 proposes but a reserve for life – an input.[2]

This book is presented in two sections.

Section 1 – An introduction to the background of the book is followed by a literature review on how indigenous peoples view health and illness. The book expands on the role of women on health matters and suggests that the struggle for women's recognition as health managers is similar to the struggle by indigenous peoples for the recognition of their knowledge. It further presents critical research findings that emerged from the PhD study and highlights the communication problems that existed in the research site between the biomedical health

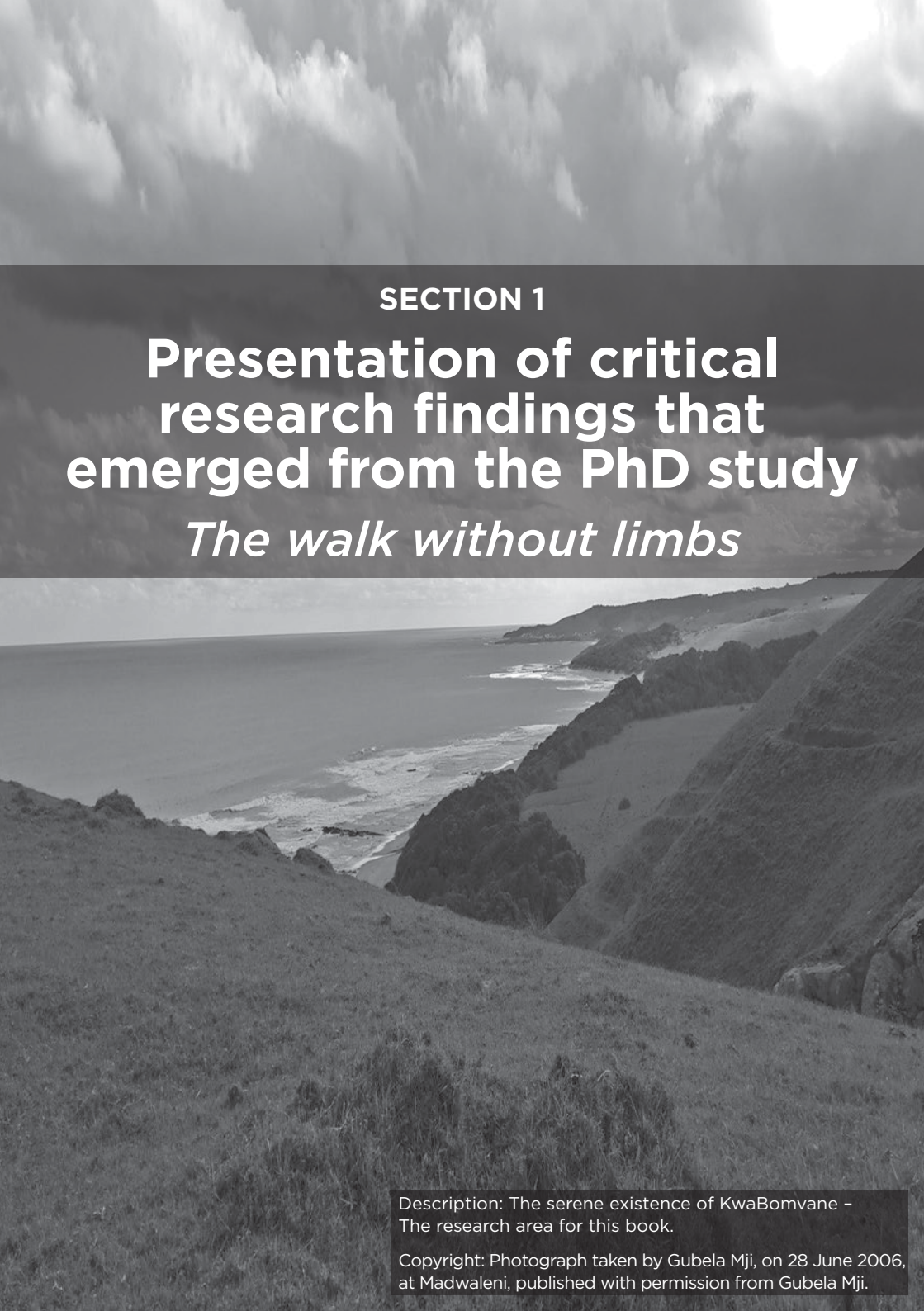
professionals and their indigenous patients, including the difficult challenges experienced by this community as it struggles with new entries that brought new knowledge systems to their quiet existence. This section comprises eight chapters and ends by presenting the elite older Xhosa women as the last chapter of this section.

Section 2 – In this section, the book further reveals how these critical research findings and recommendations were implemented in the research site. The translation of the research outcomes has been a collaborative effort between the community, guided by key stakeholders, health professionals from the secondary hospital and the eight clinics including other researchers who have worked in the area, and the scholar–activist team from the three universities in the Western Cape, the Donald Wood Foundation, the provincial government of the Eastern Cape and Happy Homes Disabled Children Centre.

SECTION 1

Presentation of critical research findings that emerged from the PhD study

The walk without limbs



Description: The serene existence of KwaBomvane – The research area for this book.

Chapter 1

Evolution of the book – Recognising the absence of limbs

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Introduction

This chapter addresses the contextual and political changes that impacted the primary health services of South Africa after 1994. This is followed by the identification of health promotion and disease prevention strategies as a basis for an effective public health and primary healthcare (PHC) system. Older women are considered key to strengthening these two health systems. Reflections of students and a facilitator on their experiences of overcrowding at CHCs and the availability of IHK in Khayelitsha are described. The influence of the explorations of facilitators and students in creating a vehicle for the exploration of IHK carried by the older Xhosa women in the Eastern Cape Province of South Africa is outlined, followed by the contextual factors that influenced the selection of the study site. The framing of the purpose for this study is outlined, and the chapter ends with a concluding statement.

The 1994 contextual and political democratic changes in post-apartheid South Africa that impacted primary health services in disadvantaged communities such as Khayelitsha

Post-apartheid political change in South Africa, brought about by the African National Congress (ANC), had an important impact on the health system of the country. In 1996, PHC was adopted as a way to ensure equitable, accessible and affordable healthcare delivery.[1] The move was supported by the proliferation of clinics and CHCs. In this plan, the clinical nurse practioner would act as a doctor, managing minor health problems and promptly referring complicated cases to a doctor. However, despite this attempt to improve access to healthcare services, healthcare delivery in some areas, even today, remains predominantly characterised by overcrowding and prolonged waiting times for patients.[2] This situation results in patients complaining about poor service and

only brief interactions with doctors and the hospital staff. There is often little opportunity for patients to express their concerns. Sometimes, patients are given medication without any explanation about the illness or the effects of the medicine.[3,4,5]

The Alma Ata Declaration of 1978, and the health changes in South Africa post-1994, generated an expectation of better health services. Alma Ata recognised that health improvements would not occur by just developing more health services or by imposing public health solutions from the top–down.[6,7] It heralded a shift in power from providers to the consumers of health services and the wider community.[8,9] However, the health services transformative agenda of post-1994 failed to address how people in the community were managing their health earlier.[4,9] In areas such as Khayelitsha, where the availability of healthcare services had improved, people were still not able to access these services as there was no proper planning regarding the implementation of the new services in this area.[3,5,9] According to Ridde et al.[10]:

> Health is created in the context of everyday life where people live, love, work and play. Failing to meet the fundamental human needs of autonomy, empowerment and human freedom is a potent cause of ill health. Health is not only a state of well-being as the WHO definition of 1948 proposes but a reserve for living – an input. (p. 44)

Hence, PHC emphasises a community development approach that is participatory and intersectoral.[11] The situation of CHCs being overcrowded is a reflection of ill-health prevalent in the home and the community level.[4,9,12] This has never been so clearly portrayed as in Mondli Makhanya's[13] editorial comment in the *Sunday Times* in 2007, which states that the new South Africa has witnessed many positive changes, as well as many new problems that have not been addressed.[13] This links to the problem of imposed PC services that have not taken cognisance of community-based health resources such as IHK before implementing primary health services in places such as Khayelitsha. The challenge now facing healthcare professionals in PC settings is overcrowding and patients who have attempted self-medication before visiting the clinic, mainly because they

had limited access to public healthcare. Also, there is a general belief amongst the health professionals that the patients have made the condition worse.[4,5] The situation at that time appears to be as follows:

- There is a public healthcare system (PHCS) budget that fails to address inequities in health. The PHCS is predominantly used by the poor who remain sick as inequities persist. The South African Private Health Care Sector, though catering for only 16% of the South African population, gets a budget close to that of the PHCS.
- Gesseler,[4] and Mlenzana and Mji[5] describe the type of services offered in these centres. Fragmentation is the order of the day with little attempt at an integrated, interdisciplinary approach, which links PHC to health promotion and prevention of disease.[14,15] For example, if a doctor is too busy to educate a patient during a consultation, he or she does not refer the patient to a lower level worker for this purpose.
- There is a general lack of research and research evidence on PHC models that have worked or the moving of evidence-to-action. In Africa, specifically, much of the research has been concentrated in English-speaking countries. Furthermore, the research arena is marked by competition amongst academics for research funds. Interdisciplinary research has not come into vogue.
- In South Africa, there are unspent budgets because of poor planning and a lack of human resources. This exacerbates health inequities and results in inadequate service delivery.[5]
- Although this PhD study was completed in 2013, literature points to the fact that the above situation still persists today.[16,17]

To further highlight the above-mentioned problem of overcrowding at the CHCs and the failure of the democratically elected ANC government to implement the comprehensive PHC strategy that was coined in the Alma Ata Declaration in 1978, a case study of Khayelitsha CHCs is presented below.

At that time, in Khayelitsha, we focussed on two CHCs (Site B and Michael Mapongwana), as these were the sites wherein our university students were placed for service learning. These CHCs

are overcrowded with patients regularly, with a large number presenting with MHAs. Minor health ailments are defined as back pain, burns, colds, minor cuts, stomach aches, insect bites, nosebleeds and rashes.[5,9,16] Because of an influx of MHA patients, healthcare professionals struggle to provide adequate attention and care to patients presenting with more serious ailments or engage in community health education.[5,16,17,18,19,20,21,22,23] Hardly any sense of trust is built between the healthcare providers and the patients because of time constraints in listening to patients' concerns, to alleviate their fears and anxieties or to educate them.[5,13,18,19,22,23]

Mini-epidemiological studies were conducted in 2000 by Brice et al.[19] and Keraan et al.[20] regarding patients who attended these CHCs. These studies showed that each CHC managed between 300 and 400 patients per day, the majority of whom were aged between 20 and 49 years, and that 24%–33% of these patients presented with MHAs.[5,19,20,21]

Similar studies were conducted in Khayelitsha by Cooper et al.[19] to determine the relationship between urbanisation, health status and the use of health services. These studies reported that 4.3% of the patients presented with common acute illnesses, such as abdominal pain, diarrhoea or gastroenteritis and vomiting, influenza and colds, upper respiratory tract infections, headaches and rashes.[19] The most common complaints were diarrhoea, abdominal pain and upper respiratory infections. The findings of Cooper et al.[21] regarding the top 10 reasons for all patients visiting the Nolungile CHC[21] in Khayelitsha resonate strongly with the findings of Brice et al.[19], Keraan et al.[20] and Nsisi[22]. Some of the reasons for these visits to the CHC mentioned by Cooper et al.[21] included coughs, local erythema or rash, sore throat and back pain, as well as repeat visits for chronic diseases such as hypertension, diabetes and epilepsy. Other studies conducted by Nsisi[23] in Retreat CHC, Myburgh[24] in Eerste Rivier CHC and Loghdey[25] in a CHC in the Southern suburbs cited ailments similar to those of the previous studies by Cooper et al.,[21] Brice et al.[19] and Keraan et al.[20] The issue of overcrowded CHCs in Khayelitsha

was presented to community health forums that included health professionals, members of the community and the elderly people of the area. The older people in Khayelitsha advocated that the management of minor health issues should be dealt with in the *home situation*, thus freeing the health professionals to educate persons on healthcare and maintenance. The healthcare services are currently unable to fulfil this role as they are overburdened. Mlenzana and Mji[5] exposed the complex relationship between health professionals and their patients. They further expanded on the multiple dimensions of health, including our way of life, and how this has both direct and indirect effects on our health.[5] Health promotion and disease prevention create a basis for an effective public health system and PHC.

Identifying health promotion and disease prevention as a basis for effective primary healthcare and public health systems

The quest to address inequities and improve health has focussed on gathering information about what works, but from a viewpoint of deficit, that is, there is a tendency to focus on identifying the problems and needs of populations that require professional resources, rather than focussing on the assets that already exist within these populations, which could be utilised more effectively. This deficit point of view creates a high level of dependency on hospital and welfare services.[24] It leads to policy development that focusses on the failure of individuals and local communities to avoid disease, rather than on the potential to create and sustain health and being able to see this as an ongoing development.

Targeting poverty alone cannot address inequities but could result in even more inequities;[25] Likewise, addressing health needs with only medicalised interventions merely exacerbates health problems and the underlying inequities. For example, when a

patient has to wait the whole day at a CHC for a Panado, leaving his or her children all alone at home with no one to care could expose the children to other health hazards. Current health approaches, based on the deficit model, have stimulated a desire for instant gratification in communities. While this model is essential for evaluating the gravity of a specific health problem, there is also a need for recognition that health is created; as people evolve, they continuously define their own health. Health does indeed become 'a reserve for living'.[10]

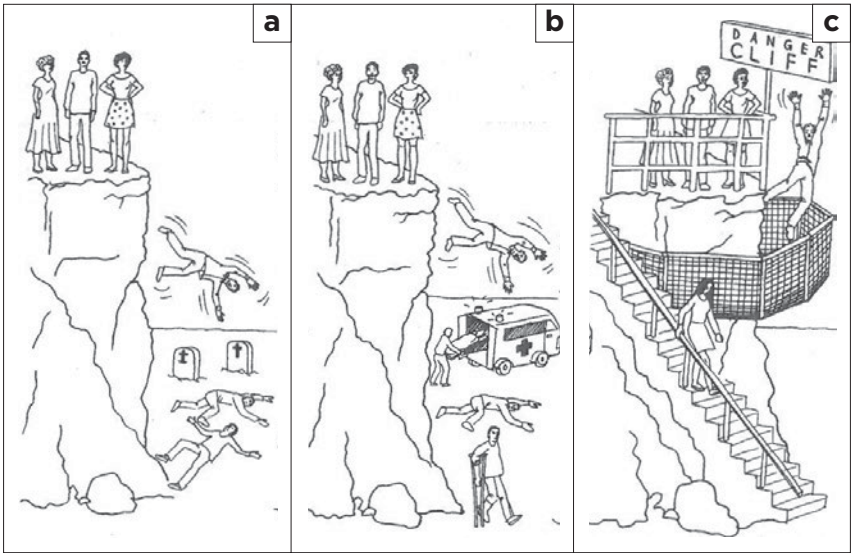
Katzenellenbogen et al.,[26] and many other public healthcare specialists, are of the opinion that the world economy, and natural resources, within the present-day circumstances, simply cannot cope with an approach that appears to have a high incidence of preventable disease, which results in a large number of patients requiring curative treatment and rehabilitation.[26] This perspective flies in the face of health systems that proudly claim to have prevented and contained the death of these individuals with expensive drugs that drain the public health system, leaving hardly any resources that could be utilised for the development of healthy communities.

Public health scholars, such as Katzenellenbogen et al.[26] and Ridde et al.,[10] perceive that preventative measures of all kinds in addressing the occurence of chronic disease and the impairment debate are the most cost-effective steps that public and private sectors should take and implement in order to alleviate and cope with impairments and disease worldwide.[8,26,27,28] These researchers acknowledge that not all impairments and diseases are preventable, but by starting to develop programmes that target prevention, early detection, prompt and proper intervention, community-based rehabilitation (CBR) and social integration, public healthcare providers will be able to address some of the challenges of the revolving door syndrome that appears to characterise the public health services of today. Health professionals appear to be content in treating the patients who come through the doors of health services without trying to gain

an understanding of the most important attributes of a public healthcare provider – the understanding of the cause of illness. The following poem by Katzenellenbogen et al.[26] demonstrates how public healthcare service providers by neglecting disease prevention and health promotion face a challenging time (see Figure 1.1):

> It was a dangerous cliff as they freely confessed
> Though the walk near the crest was so pleasant
> But over its terrible edge there had slipped a Duke and fall many a peasant
> So people said something would have to be done
> But their projects did not tally
> Some said, put a fence around the edge
> Some an ambulance in the valley. (p. 17)

Katzenellenbogen et al.[26] further developed a model of how public healthcare providers could approach the area of disease



Source: (a – c) Katzenellenbogen et al.[26, p. 17]

FIGURE 1.1: The dangerous cliff, with (a) no prevention, (b) secondary and tertiary prevention, and (c) primary prevention.

prevention and health promotion. Four stages are included in this approach (see Table 1.1).

The four prevention strategies mentioned in Table 1.1 emphasise the following:

- coordinated referral system
- inclusion of training programmes
- public education and awareness-raising
- key performance indicators that can be used to monitor progress.

Although this chapter adopts Katzenellenbogen et al.'s[26] model on health promotion and disease prevention, the authors noticed that these public health specialists were silent on enhancing the public health services in South Africa using community-based assets such as the IHK carried by the older Xhosa women in Mji's[1] study. The community health forums that discussed the problem of overcrowding at CHCs in Khayelitsha recognised the complexity of health-seeking behaviours. They placed this behaviour within the primordial and primary prevention[27] context of an environment,

TABLE 1.1: Levels of prevention and health promotion strategies.

Primordial	Primary prevention	Secondary prevention	Tertiary prevention
Disease prevention and health promotion:	**Averts occurrence of disease:**	**Early detection screening programmes:**	**Treatment of disease and rehabilitation:**
• Target lifestyle factors with high risks • Target groups where risks are not yet high (health promotion)	• Encompasses health promotion and specific protection • Controls environmental causes of disease, occupational hazards • Immunisation • Prophylactic medication	• Early diagnosis plus prompt treatment slows/controls progression • Intervention programmes; strong referral systems • Public education	• Treatment plus rehabilitation to optimise function, prevent/minimise secondary impairment • Occupational training • Re-integration into the community

Source: Katzenellenbogen et al.[26]

pointing to issues of migration, broken family units, displaced traditions, including lack of integration of community-based resources, such as IHK carried by the older people.[1] This notion is supported by Bührmann,[29] who asserted that the concept of 'community involvement' implies that healthcare is not only the responsibility of external agencies, and especially trained health practitioners or family physicians, but that the whole community has to ensure that the health of every member is maintained at an optimum level. She argues that health in many preliterate societies depends on the survival of the group through the ability of all individuals to fulfil their roles, as well as through the knowledge of healing being passed on across generations.

The challenge today is to instil a sense of pride in the descendants and the owners of this huge repository of traditional health knowledge and medicine so as to make them confident enough to share it with others. Zonke,[9] Gumede[32] and popular papers such as the Reader's Digest Association South Africa[33] explain how healthcare changes in South Africa have affected the status of indigenous knowledge, including the acknowledgement of the practice of home-based IHK. They emphasised that in the past, the rural community were not used to hospitals. They managed their ailments through home remedies provided by older persons. In the *home situation*, taking the sick person to a traditional healer was a form of referral that was resorted to only once home remedies had failed.[4,6]

Traditional knowledge is an important part of South Africa's cultural heritage. Before synthetic chemicals were developed, plants were one of the main sources of ingredients for medicines. They were also used as a source of food and as material for equipment. Wherever there was colonisation by the Western powers, this knowledge became redundant. South Africa, however, cannot afford to embrace an exclusively Eurocentric medical approach.[29,32,33] Eisenberg et al.[34] maintained that other forms of medicines that are not within the biomedical paradigm are generally used as an adjunct to biomedicine, rather than as a replacement. In Eisenberg et al.'s[34] study on unconventional

medicine in the United States, one-third of the respondents who used unconventional therapy in the 1990s used it for non-serious medical conditions, health promotion and disease prevention.

Mlenzana and Mji[5] and Zonke[9] describe the level of mistrust that develops between health professionals and patients when the latter resort to self-treatment using home remedies. This results in the patients being chastised by health professionals for attempting home-based health management. This type of approach creates secrecy and mistrust, with health professionals perceiving the patient as having used some form of 'voodoo *muthi*' prior to coming to the health centre. Because of this situation, the researcher conceptualised that the study would assist in the following ways:

1. lift the veil of secrecy so that health professionals acknowledge the existence of IHK
2. identify dangerous practices that might still be part of IHK, as unlike allopathic medicine, IHK has not been given a platform for testing and validation – as hidden knowledge, it appears that this knowledge system was ultimately expected to die
3. return status to the *home* and acknowledge it as being the nucleus where health issues can be *contained and maintained*
4. ultimately affirm the status of the older women as being the *first-line health practitioners* who can form an important part of the PHC system in their respective communities.

The identification of the older women as key to strengthening primary and public health systems

Kleinman's[35] Cultural Systems Model suggests that in any complex society, three overlapping arenas of healthcare can be identified: the popular, the folk and the professional. It is, however, important to note that this model is frowned upon by experts in IHK, as it approaches culture as homogeneous and unchanging rather than as dynamic and heterogeneous.[36,37]

Although it would be easy to place the IHK carried by the older people within Kleinman's[35] popular arena of healthcare, the participants in Zonke's[9] and Mji's[1] studies identified an exhaustive list of ailments that could be managed at home. Therefore, the researcher postulates that in rural areas, the older people, specifically women, have been filling a vital healthcare gap in South Africa's young democracy and during its attempts to organise the delivery of a comprehensive PHC service. During critical times of illness, homes and communities have had to resort to whatever healthcare resources are available to them. This is especially apparent in rural communities where access to healthcare services is still a challenge. This notion is supported by Gessler et al.,[4] who maintain that in rural areas, because of their long distances from healthcare facilities, alternative medicine may be the only available source of healthcare within reasonable reach. This is also confirmed by Mji[1] in her PhD study of the management of health problems by the older Xhosa women in their home situation, with a focus on IHK. Mji[1] thereby further affirms the views of Achterberg[38] and Clough[39] on the role played by the older women in supporting their families. This study also attempts to show that where health services are available, responsibility for the management of MHAs has shifted from the home to the health professionals, resulting in the overcrowding of CHCs with MHA patients.[6,10,13,34]

Scott and Wenger, cited in Boneham and Sixsmith,[40] examine how age and gender frame or structure women's accounts of their health. They argue that women can become more powerful and autonomous in old age, taking on new roles and duties. Boneham and Sixsmith[40] maintain that the voices of the older women are rarely heard in debates about health. Consequently, there is little research on the ways in which the older women contribute to the health economy and social capital of their communities. In South Africa, with the high prevalence of HIV and AIDS, the older people, specifically women, have become the pillars of strength for AIDS orphans. Achterberg and Clough[38,39] raise the issue of how women have always been carers and

healers, but women's legal right to practise their healing vocation has been gradually eroded by changing mores. This can in part be remedied by:

1. recognising and valuing the older women as key players in community health and as lay experts who are widely consulted by family and friends
2. promoting a greater understanding that the knowledge carried by the older women is passed on by word of mouth across generations, and that if this knowledge is not researched and documented it will be lost to future generations.

Sinnot and Wittmann[42] maintain that there is insufficient documentation of IHK, although there is increasing recognition of its importance in good healthcare delivery. In their study in Queensland, Australia, they implemented a three-tier plan to equip doctors with the necessary cultural awareness about health issues in order to facilitate positive experiences with indigenous patients. The rationale for Sinnot and Wittmann's[41] three-tier plan was that many positive, persuasive attitudes regarding indigenous health could be maintained and modelled by the more established doctors within the hospital structures. Dr David Cumes,[42] a biomedical surgeon who converted to a Sangoma and a bone thrower, maintains that the very placebo effect that biomedical researchers use for their randomised control trial studies of efficacy is a valuable tool in the containment and prevention of patients from using aggressive medications. These authors conclude by proposing that an important step towards improving the health of indigenous people is the introduction of a culturally appropriate health science education programme.[38,39] We are optimistic that recommendations from this study will influence the curricula and education programmes of the Health Sciences, as well as research in the Faculties of Health Sciences at South African universities, thus eventually impacting the clinical practice of these professions.

The older Xhosa women, in the introduction chapter of Mji's[1] thesis, expressed concerns about being chastised by health

professionals for using home remedies prior to visiting the PHC centres in Khayelitsha, Cape Town. This is a common anxiety heard by many researchers, who are requesting health professionals at the primary level of care to, firstly, try to understand what approaches and medicines people use at home when they are faced with the illness of a family member; secondly, to learn about the effective as well as the dangerous aspects of these approaches; and, finally, to be more proactive in trying to integrate the two health systems.[5,9,1] It is against this backdrop that, as student facilitators, we first had to acknowledge that two health systems are operational in South Africa: The biomedical healthcare system that only started to be seriously implemented in these communities after 1994 and the indigenous healthcare system that has existed for a very long time. We concluded that there was a need to have an in-depth understanding of the health-seeking behaviour of patients using these two health systems and to understand the IHK assets that exist in Khayelitsha. This exploratory work is presented in the form of case studies from both the students and facilitators in this area.

Reflection from students and a facilitator on their experiences of overcrowding of community health centres and availability of indigenous health knowledge in Khayelitsha

This section describes three case studies that exemplify the contribution of health science students and their facilitators in service learning and the contribution they make in disadvantaged communities such as Khayelitsha. These colleagues are contributors in this book and contributed to this first chapter to highlight the indigenous lens that this book utilises, specifically that: *Intaka yakha indlu ngoboya benye* [birds share feathers when building their homes], and secondly that: *Umntu ngumntu ngenxa yabanye abantu* [at the core of individual strength and success is the contribution of time and resources by others].

The case studies have been organised in the following format:

1. The fourth-year physiotherapy student's story: Who, on a cold winter day, I started assisting, thinking why mothers of children were filling the CHC and waiting the whole day for an inhaler instead of managing this at home. Unfortunately, because of a change in rotations (as is the norm for physiotherapy students to change placements to a different location after 6 weeks), I did not continue with her in further unlocking this problem and other self-management strategies that are used at home.
2. The medical student's facilitator's story: Who at that time was facilitating from the Department of PHC at the University of Cape Town (UCT).
3. The two master's students' stories: At that time, they were rehabilitation clinic workers at Michael Mapongwane CHC.

The fourth-year physiotherapy student's story

I am a white person who was raised in an affluent and privileged home during the time of apartheid in South Africa. I went to a wonderful, nurturing school, which offered a very high quality of education and had committed and caring teachers. After completing my matriculation, I went on to study physiotherapy at an acclaimed institution of higher learning in Cape Town. During this time, I had my narrow vision of South Africa opened to a bigger picture of South African society, including areas about which I had somehow remained ignorant. I met patients from all walks of life, and really enjoyed getting to know them and learning, in little snapshots, about the different spaces we occupied in our 'shared' city, and as a result, our different experiences of hardship or ease in our lives.

As part of this institution, I joined some of the non-governmental organisations (NGOs) that students were involved in and acted as a representative for my student professional group in one organisation. I remember going to *Imizamo Yethu* in Noordhoek in the evenings with the other medical students as part of a clinic

that saw outpatients. I was trying to do a back class there. (I find that funny now that I know a little more about life, and how inconvenient an evening back class would be for people: People who were working in the suburbs would have been travelling late in the evening and still had lots of responsibilities in their home. Secondly, areas without good policing and lighting do not encourage much walking around in the evenings. I also think that people with back pain are probably not very keen to exercise in the cold evenings just before going to bed.)

In this way, I tried to get involved and to contribute in the way I thought I could. I remember, as a member of the student committee for this NGO, going to a faculty meeting where student safety was discussed. The staff members were weighing the benefits against the disadvantages of the students going to the 'higher risk' areas. I remember observing a collective decision that it was more important for students to go to these areas (mostly poorly resourced, lower socio-economic areas of informal housing where crime was poorly controlled), in order for the university to have an impact where it was needed and for the students to get an experience in all of South Africa's contexts. I remember being quite indignant on behalf of my fellow students that they were being treated like pawns and exposed to risky neighbourhoods, that they might possibly be 'sacrificed' for the greater good of the bigger cause.

When I look back now, I am proud of those staff members who ensured that we had that experience, and who gave us a chance to really see, and to start to question why South Africa was (and sadly still is) like that. I had a few rotations at various places in Khayelitsha, for example. One was supporting care centres for children with disabilities. Perhaps, I started to gain an understanding there, but I am embarrassed at how ignorant I was about people's everyday lives back then. It is really hard to offer appropriate support when one has really no inkling of another person's life. In recent years, I have strongly encouraged community service for incoming young professionals of my discipline, whom I oversaw at a rural district hospital, and to

spend time at a home in the area, to get to understand the daily routines, the various challenges of living in a rural space, so that in their community service year they would offer realistic advice and interventions to their patients.

Perhaps, I strongly advocated this because I recognised in them what I had had in myself: A total ignorance to the point of not even being able to imagine another's life. I did my final fourth-year block at Khayelitsha Day Hospital. Every morning, I drove in the gates, past the vendors on the street. One vendor sold what I thought were little mats. At the end of my block, I walked to the nearby shop to price some items that we were thinking of advising some moms to get for their children. Imagine my surprise when I discovered my little mats were part of cow intestines. Not only did they have a completely different purpose, but I also had never been aware that cow intestines were edible! As you can tell, my ignorance was extreme (and today, 19 years later, I am still finding out how much I still have to learn).

It is difficult to identify exactly when you change, or exactly what learning is internalised, and I cannot say that I would not have learnt what I know if I had not gone on the 'community' blocks. I know that I loved going there, that I never complained about the risk to myself or the long drive times from the campus. I loved being in a community, not a hospital or institution. I loved getting to know people and their stories, seeing their homes, as well as learning about people and their lives, and in that way learning about my own life too. I have continued with a passion for 'community' physio in my career. I worked in rural district hospitals, most recently in the Eastern Cape, and loved living in the village, especially really knowing our patients – following them through acute care, then rehabilitation, to their nearby clinics and visiting them in their homes. I love being a physio, and I love how physios can enhance lives, especially in times of injury and illness, and my frustration is that the places that really need physios, where we would have the maximum impact for our time spent, are the places in South Africa where the physios are the scarcest – the rural areas.

The facilitator's story: Reflections on exploring indigenous health knowledge in Khayelitsha

In January 1996, I joined the PHC department of one of the institutions of higher learning in the Western Cape Province of South Africa. My responsibility was to coordinate with fourth-year medical students in completing an 8-week community-engaged block. The main aim was for students to complete an epidemiology and health promotion project on a challenging issue in the community, identified by community members and/or health workers in the community. Throughout the project, they worked in consultation and partnership with community members and health workers. One of the communities where students were placed was Khayelitsha. One challenging issue that was noted by students, community members and health workers alike was the overcrowded CHCs and satellite clinics, but CHCs in particular.

At the same time, one of my colleagues, Gubela Mji, who is the first author of this Chapter, was responsible for placing physiotherapy students in Khayelitsha, and we joined forces. We wanted to research what brought so many people to the CHCs. They had to get there early in the morning, queueing from about 04:00 or 05:00 if they planned to be seen that day. Some were even turned back and had to come the next day. We assumed that many came with minor ailments that could mostly be treated by knowledgeable older people at home using their IHK. After meetings with some of the CHC staff –some nursing sisters, the CHC physiotherapist and occupational therapist – we decided that the medical students could do their epidemiological studies focussing on health-seeking behaviour of persons in the overcrowded waiting rooms. At the same time, the health workers and the site facilitator for the medical students encouraged the elderly in the community to come to the meetings and share their IHK for minor ailments.

As part of their research projects, the medical students documented these remedies. These were very basic research

projects, but they formed the basis for two master's students to research further. It was fascinating to hear what minor ailments the elderly could treat at home and how they treated the ailments. Most made scientific sense. It reminded me of the remedies my grandmother, aunts in the small town and workers at the hotel my parents ran used when we had minor illnesses. After a number of meetings with the elderly people of Khayelitsha, they suggested that to gain more knowledge we should go to the elderly in the rural areas of the Eastern Cape. They stated that by living in the city and having relatively easy access to allopathic medication, they had neglected and forgotten much of their IHK.

The master's student's story: Reflections on doing indigenous research in Khayelitsha

In 2000, prior to and during our master's studies, we were working in a CHC in Khayelitsha, a semi-informal settlement. Khayelitsha, a peri-urban area, was initially started as an attempt by the previous apartheid government to move all Africans near the city centre to areas further away from the city and suburbs occupied, at that time, by mainly white people. We were part of a rehabilitation clinician team (physiotherapists and occupational therapists) dealing with patients of different age groups. Joining CHCs connected us with people who were communicating in isiXhosa, our own home language. This was an advantage as patients were able to express their ailments in their own mother tongue. We were happy and encouraged our patients to open up as some ailments were linked to social circumstances. As we were settling into our clinical rehabilitation work, we were approached by facilitators from the UCT to engage in research targeting overcrowding in CHCs and exploring indigenous health assets carried by the older people within Khayelitsha and Phillipi. This research focussed on exploring management of MHAs at CHCs and how elderly people managed these ailments. The elderly people were targeted as this had already been suggested in community health forums by the older people – that the IHK lying

dormant in Khayelitsha home settings could be used to manage minor and major health ailments at home. Our research then focussed, firstly, on the problem of overcrowding and the health-seeking behaviours of persons who were overcrowding these CHCs; and, secondly, on exploring whether there are community-based assets such as IHK carried by the older people of Khayelitsha that could be used to strengthen the health systems. We were two researchers, one exploring the health-seeking behaviours of persons using CHCs in Khayelitsha and Phillippi – a total of four CHCs – while the other exploring the IHK carried by the older people in Khayelitsha. Table 1.2 presents the list of MHAs that older people could manage at home.

For the study on the health-seeking behaviour of persons using the four CHCs, 100 participants were interviewed (25 in each of the four CHCs). Table 1.2 was used to identify MHAs that the older Xhosa women have skills to manage at home. Table 1.3 presents the number of persons that were seen by the participating doctors and clinical nurse practitioners (CNPs) presenting with MHAs on the day of the research for each CHC.

TABLE 1.2: List of MHAs.

Respiratory	Abdominal and UTI	Skin disorders	Body pains	Ears	Accidents
Colds/flu	Diarrhoea	Insect bite	Chronic back pain	Blocked ears	Minor cuts
Upper respiratory tract infection	Stomach ache	Rash	Acute back pain	Earache	Nose bleed
Hay fever	Vomiting		Migraine	Ear discharge	Minor accidents
Tight chest	Burning urine		Emotional problems		Minor burns

MHAs, minor health ailments; UTI, urinary tract infection.

TABLE 1.3: Number of persons seen by the participating doctors and CNPs with MHAs.

CHCs	Patients seen by doctors and CNPs	Patients with minor health ailments	Per cent for MHAs
Michael Mapongwana	167	118	71
Site B	343	220	64
Inzame Zabantu	85	50	59
Mzamomhle	91	45	49

CHCs, community health centres; CNPS, clinical nurse practitioners; MHAs, minor health ailments.

The researcher was surprised to see what the elderly people confirmed as MHAs. These listed MHAs that the older people were confident that they could manage at home were similar to the health ailments that were documented in patients' folders at the four CHCs in Khayelitsha and Philippi during the document review.

By looking at data in Tables 1.2 and 1.3, and the list of minor ailments that can be managed at home through home remedies, it can be inferred that if health professionals in the four CHCs support the older people in the management of MHAs, CHCs will have more time to focus on serious illnesses.

The Department of Health will benefit more if it can engage with elderly people to safely manage these ailments at home. The elderly people can also be recognised as a resource in the community for the management of MHAs. Further enquiry was conducted to get to know the MHA patients presenting at the CHCs. Table 1.4 shows different age groups of patients who presented with MHAs.

The master's student who explored the MHA patients that presented in CHCs said that, for her, the approach of involving elderly people in the research reminded her of her home in the Eastern Cape, where her grandmother used home remedies for some of the ailments they had when they were growing up such as headaches, mumps, boils and minor burns.

Elderly people from Khayelitsha and Phillipi were also from the Eastern Cape. It was interesting to listen to what the elderly

TABLE 1.4: Combined age group of persons who participated in the study from the four CHCs presenting with MHAs.

Age group	Number of persons	Percentage (*N* = 100)
18–29 years	52	52
30–39 years	26	26
40–49 years	16	16
50–59 years	5	5
60–65 years	1	1

MHAs, minor health ailments.

people shared with us during focus group discussions (FGDs). They were very clear on how they managed different ailments in the Eastern Cape but could not continue using the herbs that they used because of unavailability of these herbs in Cape Town.

Influence of the explorations of facilitators and students in creating a vehicle for the exploration of indigenous health knowledge carried by the older Xhosa women in the Eastern Cape Province of South Africa

In community health forums, the older women proposed that there are community-based resources such as IHK carried by the older Xhosa women that could assist in addressing the overcrowding of CHCs by MHA patients. In the research by the master's student on health-seeking behaviours of patients attending CHCs and the exploration of IHK carried by the older people, the latter exhaustively listed ailments that they thought could be managed at home. They were unhappy about having their knowledge described as 'management strategies for common or minor health ailments' because they maintained that over the years there was no distinction between minor and major health ailments and that all health ailments could be managed and contained within the home situation. Below are some of the issues that emerged when we started revisiting the issue of exploring IHK from the lens of the older Xhosa women residing in Khayelitsha.

Retention of indigenous health knowledge by the older women

Questions arose about the retention, and the validity, of IHK by the older women because the majority of them had come to Cape Town about 20 years back. The older women stated that

their families did not give them the same status that they were accorded in their rural homes, which would enable them to manage health problems at home. They were seldom consulted when somebody was ill. Instead, people went to the CHCs. The older people acknowledged that it was long since they were given free rein to practise their healing vocation at home. Hence, they feared that they may be out of touch with their IHK.[4]

Availability of indigenous herbs or medicines in Cape Town

The older women revealed how they had learnt their IHK from their grandmothers in the rural Eastern Cape, and that this was where they had started practising their healing vocation. However, they complained that they experienced difficulties in Cape Town when trying to obtain the necessary indigenous herbs or medicines to use. Hence, in order to obtain a true depiction of the healing capabilities of the older Xhosa women and the indigenous herbs or medicines that they use, it would be necessary to examine the IHK of the older women in the Eastern Cape – their place of origin. A further link between the older Xhosa women who were interviewed about being carriers of IHK and people who overcrowd the CHCs with MHAs lies in the fact that 80% of both groups originate from the Eastern Cape.

Impact of the preliminary studies conducted in Khayelitsha about indigenous health knowledge of the older Xhosa women

The case studies influenced the choice of participants and the study site, the boundaries of the study, adjustments made to the objectives and tools, and adjustments made to the depth and scope of the study. Below is an explanation of how the case studies influenced these areas.

Participants and the study site

South Africa consists of a multicultural social setting of 11 official languages situated across nine provinces.[36] Within these different cultures and settings, there are differences and variations as to how the older people contain and manage health problems at home.[37] Mji's[1] doctoral study began with the identification of the problem of overcrowding at CHCs by persons in urban Khayelitsha, which has a population that is predominantly Xhosa.[1] In the preliminary studies, the older people who affirmed that health problems in general and MHAs in particular could be contained within the home situation had originally hailed from the rural Eastern Cape.[4,6] Therefore, the doctoral study turned its attention to IHK carried by the older Xhosa women who reside in the Eastern Cape Province of South Africa.

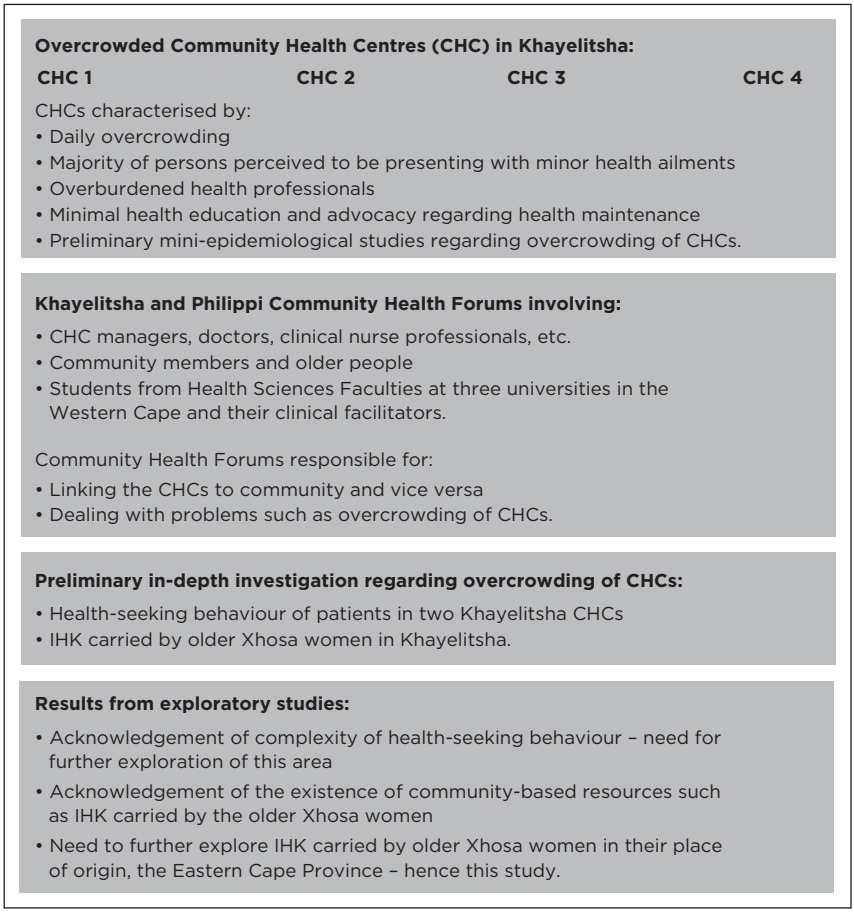
Boundaries of the study

In the exploratory study on IHK carried by the older women, the FGDs occurred in urban area senior citizen club halls. The area in which the participants practised their healing vocation was their homes. In the doctoral study, the researcher conducted the study amongst the older people in the Eastern Cape, in their natural environment in which they practised their healing, namely, the home.[4,6,37] The older Xhosa women from the community health forums in Khayelitsha and Phillipi proposed that the oldest female holds the highest position in the hierarchy regarding the management of health problems in a traditional Xhosa home.[4] This suggestion was further affirmed by the doctoral thesis.

Adjustment to objectives and tools

The older people disagreed with the notion that their healing vocation was only for MHAs. They said that when somebody is sick at home, especially at night, the approach would be to contain the illness through the alleviation of pain and suffering, as well as making the sick person feel supported and cared for, rather than differentiating whether the illness is minor or major.[4]

In addition, there was the geographical problem of health services being far away. In the Eastern Cape, the majority of people still struggle to gain easy access to health services because of the long distances to travel. Therefore, the older Xhosa women would be the first to be consulted when containment of illness was necessary at home. The doctoral study therefore set out to explore all health problems that are managed by the older Xhosa women at home. Figure 1.2 presents a summary of preliminary



Source: Mji.[1]

FIGURE 1.2: The influence of contextual issues on the selection of study site.

works that contributed to the delineation of the research question and guided the study regarding its purpose and objectives.

Identification of the research site

Considering the outcomes of exploratory studies in Khayelitsha, the place that was identified as the research site for the doctoral study was *KwaBomvana* in *Xhora* (Elliotdale) in the Eastern Cape Province of South Africa. The *Amabomvana* people who reside here are one of the most interesting tribes in South Africa.[42] They speak Nguni-Xhosa, a Bantu language spoken by more than 3.9 million South Africans. The breakdown of their tribal economy forced the traditional *Bomvana* towards the turmoil of rapid cultural change. This process of acculturation in South Africa, which forced thousands of Africans to work primarily as labourers in the mines, was orchestrated mainly by the industrial powers. The impact of migrant labour on *Bomvana* life cannot be overestimated; their manpower in the vital period of life (18–50 years) was continuously withdrawn from their tribal society and economy and mobilised for the labour market.[30] A detailed account of the research site is further presented in Chapter 4.

Framing the purpose and objectives for the exploration of indigenous health knowledge of the older Xhosa women in the Eastern Cape Province of South Africa

Guided by the indigenous scholars, predominantly women, who hailed from the Eastern Cape Province of South Africa, the *primary* purpose was to explore and describe the IHK of the older Xhosa women and how it was used in the management of all health problems in their home situation. The second purpose was to make recommendations to key stakeholders regarding the use of this IHK in the management of health problems in the home

situation, especially with new intentions of the South African National Government to revive primary health and the promised National Health Insurance (NHI).[1]

Primarily, the objectives of the study were to explore, examine and describe the following IHK carried by the older Xhosa women from the Eastern Cape:

- their definition of health and illness
- the health problems that they manage at home
- the steps that they take to decide or diagnose what specific health problem the person has
- the steps and management strategies that they use at home to deal with these health problems
- the home remedies that they use to manage these health problems
- whether different types of health problems (such as the critical health-related incidences) influence their decision-making
- the rationale that would lead to their giving up health management strategies at home and referring the person to an outside source
- the referral sources that they would use to further manage the illness and the rationale for that choice
- their opinions regarding how their knowledge could be integrated into the present healthcare dispensation, including the contribution it could make.

Secondly, the study aimed to design and suggest a model for the integration of the IHK carried by the older Xhosa women in the present PHC system, and make recommendations to key stakeholders regarding the future of this knowledge, including training options.

Concluding statement

Although the ANC-led government wanted improved access to health services, especially for peri-urban and rural areas, by implementing PHC, the government failed to implement the comprehensive PHC strategy of 1978 with a focus on disease

prevention and health promotion. Also, there was no focus on the IHK that was dormant in these communities. Exploratory studies conducted in CHCs in the peri-urban area of Khayelitsha, Cape Town, demonstrated that these CHCs were overcrowded with a large number of MHA patients. It was postulated that this might be leading to a situation in which persons with more serious health problems were deprived of the attention they require. These preliminary studies also explored the IHK carried by the older Xhosa women in Khayelitsha and raised questions about the validity of this knowledge and the need to explore it in the place of origin of the older Xhosa women – the rural Eastern Cape province.

The participatory and inclusive approach adopted by the community health forums and their management of the discussions, as well as preliminary exploratory work undertaken, contributed to three areas of this study:

1. the identification of the study area
2. the identification of the study sample
3. the development of the methodology.

The complexity of attempting to integrate IHK carried by the older Xhosa women into the current (biomedical Western) PHC system was recognised as one of the approaches that could address the problem of overcrowding of CHCs. Although this might seem to be one of the solutions, there was a need to take a cautionary approach instead of a unilateral approach to address the problem, as what might appear as an MHA initially could manifest into a major health ailment within the next few days. It is in this regard that the next chapter focusses on developing an understanding of the epistemology of health and illness according to biomedical and IHK perspectives, including the area of MHAs as well as what is considered to be dangerous practices for the management of these illnesses.

Chapter 2

An epistemology on health and illness according to biomedical and indigenous health knowledge perspectives

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Introduction

This chapter addresses health definitions from both an IHK and a biomedical perspective. The biomedical perspective of different

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health belief models is provided by Gilbert et al.[1] and Kleinman,[2] while an African perspective is drawn from Maelena[3] and Liddell et al.[4] The chapter first presents a description of the home as the place where health can be maintained and minor illnesses can be contained, with the older women in the home playing a pivotal role. A classification of what constitutes minor illnesses is presented, and illnesses that can be managed by alternative approaches are outlined. Finally, some insights into what could be classified as dangerous health management strategies are discussed.

Health definitions

The main focus of this section is definitions of health according to the World Health Organization (WHO) and indigenous peoples.[3,4,5,6] In 1948, the WHO defined health as '[a] state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[7, p. 1] According to Bok,[7] this definition has generated much controversy ever since it was coined. It has been called masterful but dysfunctional, profound and yet meaningless. Its meaning has been defended not only as being indispensable in its present formulation but also as needing revision. At times, it was held responsible for having opened the door to the medicalisation of most of human existence, and at other times, to the abuse of state power in the name of health promotion.[7]

Fifty-one years later, in 1999, the WHO arranged an international consultation in Geneva on the health of indigenous peoples. In 2002, a new definition of health, arising from that consultation, which links culture, the wider natural environment and human rights was offered[6]:

> Indigenous people's concept of health and survival is both a collective and individual intergenerational continuum, encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, the present and the future co-exist simultaneously. (p. 1138)

Bodeker[6] and Durie[8] argue that there is a need for health professionals to bear this definition in mind when dealing with indigenous people. Bok[7] calls for a revision of the WHO health definition of 1948. If over 60% of non-industrialised countries depend on IHK for their basic healthcare needs[8] – in some African countries this figure is estimated to be as high as 90%[8,9] – then it is logical that a universal health definition should include inputs from such population groups as well.

It is believed that traditional health systems' thought and practice, diagnostic, clinical and herbal medication reactions also include empirical frameworks for understanding health.[8] According to indigenous approaches, illnesses occur when there are disturbances between the mind and body, as well as between different dimensions of individual body functions; between the individual and community; between the community and the environment; and between the individual and the universe.[8,10,11]

By breaking the interconnectedness of life, a fundamental source of disease erupts and can progress to different stages of illness, and because of the fact that disease has found fertile ground (the broken interconnectedness), it can spread to epidemic levels.[12] Indigenous health knowledge treatments not only address the locus of the disease but also seek to restore a state of systematic balance between the individual and his or her inner and outer environment. A state of awareness, the spiritual, intellectual and emotional well-being of a person, is considered to be the basis of all material existence, and it is this state of awareness alone that appears to earth and anchor an individual.[8,10] There is a need to appreciate that the biological environment and spiritual conditions are contributors to illness.

Knowledge about the management of the natural environment serves as a natural balance to the people of an area and also contributes towards their well-being. The traditions of indigenous knowledge are systematic, as seen in the way indigenous peoples view nature and classify and select medicine. For example, in Northern Brazil, when the indigenous people were faced with the

malaria epidemic, they developed an empirical approach to identify those plants with anti-malaria effects. One major criterion was bitterness or antipyretic properties.[11]

For indigenous people, the spiritual dimension is always intrinsic to every material form, and matter cannot exist without spirit. There is a belief amongst many indigenous peoples that the properties of plants can be enhanced through understanding their spiritual connections. According to IHK, the subtler spiritual properties of plants are as real, and certainly more powerful, than the direct healing properties.[11] Some plants are representative of a woman who is good, virtuous and faithful, for example, the *Tulasi* plant in India.[11] It also has medicinal components such as antipyretic, diaphoretic and expectorant properties. Biological activity tests have shown that *Tulasi* enhances immune functioning by increasing the antibody activity.[10,11] Thus, many indigenous plants like the *Tulasi* have strong survival elements and represent enduring cultural, spiritual, religious and traditional practices in their place of origin.

Many of the traditional practices of conserving plants are being eroded by commercial enterprises. Pharmacological industries use 'local people' as their raw material collectors. The consequences are that indigenous people lose their natural habitat as well as hundreds of plant species, which eventually become extinct. The commercial usage of these plants is unlikely to promote traditional medicines, which use only a fraction of their medicinal components. The loss of biodiversity threatens not only the ecology but also the livelihoods of traditional communities that try their best to conserve traditional medicines. They interpret the commodification of their resources as exploitation because they see it as commercialisation without respect.[8,10,11]

Increasingly, as indigenous people conformed to modern civilisation, their IHK was suppressed, for example, by religious groups and colonisation.[11] Critics see these developments as being underpinned by ideologies that aim to gain power and control of certain areas and their natural resources at the expense of the health and preservation of the indigenous peoples.[11]

Health belief models

Health-seeking behaviour can be seen as a process in which the beliefs and actions of the sick person, or the people in his or her immediate social environment, lead to seeking out treatment and to subsequently evaluating the outcomes of such treatment. This process does not simply involve diagnosing, labelling and treating the illness but goes through stages in which the sequence continuously moves from explanation to therapy and to evaluation. If healing fails, the process is repeated so that new explanations are developed, and are then followed by alternative forms of therapy, which are then re-evaluated.[2]

Gilbert, Selikow and Walker's cultural model

Gilbert et al.[1] define health behaviour as an activity undertaken by persons who believe that they are healthy and aim to prevent or detect diseases during this asymptomatic stage. They suggest that illness behaviour is a culturally learnt response, suggesting that the experience of illness is defined according to the norms and values that are prevalent in a specific society or a community.[1] This approach emphasises that when symptoms are perceived as abnormal, people need to take the initiative to do something about them and to seek help. People who become ill typically access a hierarchy of resources, ranging from self-medication to consultation with others. Self-treatment is based on lay beliefs about the structure and functioning of the body, and about the origin and nature of ill-health. It includes a variety of substances such as patent medicines, traditional folk remedies, or 'old wives' tales', as well as changes in diet or behaviour.[1]

Once symptoms of illness have been recognised as serious, the activity that follows will be determined by the way things are usually done or the dominant mode of operation in a particular culture. In most communities, the first step in seeking help involves consultation with family members, friends and neighbours.

Subsequently, the person might decide to seek help from traditional healers, consult Western or modern health professionals, approach alternative sources or use a combination of these options. This process is similar to Kleinman's[2] popular and folk arenas, mentioned earlier (and below).

All communities and cultures have their own embedded concepts of health. Thus, what is experienced as health represents a complex, intimate and cultural understanding in a particular social context, rather than a fixed set of physiological and biochemical facts. Even in a culture in which scientific medicine is dominant in people's minds and outlooks, some individuals will still seek health or healing through different modalities of treatment, in certain cases based on what appears to be quite bizarre beliefs.[1,2]

Kleinman's cultural systems model

Kleinman[2] explained illness as a cultural idiom and found a relationship between beliefs about disease causation, the experience of symptoms, specific patterns of illness behaviour, decisions concerning treatment alternatives, actual therapeutic practices and evaluations of therapeutic outcomes. Thus, for Kleinman,[2] the healthcare system is a model that includes health, illness and the healthcare-related aspects of societies as articulated in cultural systems.

Each arena in the three overlapping arenas (the popular, the folk and the professional arenas) of Kleinman's[2] model has its own ways of explaining and treating ill-health, defining who the healer is and who the patient is, and specifying how the healer and patient should interact in their therapeutic encounter. Most healthcare systems contain all three health arenas, within which sickness is experienced and responded to:

The popular arena

The popular arena is known as the lay, non-professional, non-specialist domain of society, where ill-health is first recognised and

defined, and healthcare activities are initiated. It includes all the therapeutic options that people utilise, without any consultation with or payment to folk healers or medical professionals. The popular arena is seen as the real site of PHC because the family is the main and primary health resource and most ill-health is identified and then treated within the home or family. Most healthcare in this arena takes place amongst people already linked to one another by kinship, friendship or neighbourhood, or even membership of work or religious organisations. This means that both the patient and the healer share similar assumptions about health and illness, and misunderstandings between the two are comparatively rare.[2] An example of the popular arena would be the IHK carried by the older Xhosa women for the care of MHAs in their home situation.[13]

The folk arena

In the folk arena, certain individuals specialise in forms of healing that are either sacred or secular, or a mixture of both. These healers are not part of the official or the public medical system, and they occupy an intermediate position between the popular and the professional arenas. Most folk healers share the basic cultural values and worldview of the communities they live in, including beliefs about the origin, significance and treatment of ill-health. When they heal people who are sick, they frequently involve the family in the diagnosis and treatment. The healer is usually surrounded by helpers, who take part in the ceremony of healing, give explanations to the patient and family, and answer any queries. This is similar to the way Berg[12] explains the role of traditional healers. From a modern perspective, this type of healer with helpers, together with the patient's family, provides an effective PHC team.

In apartheid South Africa, especially in rural areas, people were largely left to the ministration of traditional healers, the good offices of missionaries and the patent medicines of traders. According to the WHO, professional health services were largely inaccessible to the people living in these distant areas.[14] In certain areas of Africa, this situation is still prevalent today.[14,15,16,17,18,19,20,21]

The professional arena

The professional arena comprises the organised, legally sanctioned healing professions, such as modern Western scientific or allopathic medicine. It includes not only physicians of various disciplines and medical specialities but also the recognised allied professionals such as nurses, midwives or physiotherapists. Healers in this arena examine their patients, prescribe powerful treatments or medication, and confine people diagnosed as psychotic or infectious in hospitals. When consulting a professional, the ill person is removed from his or her family, friends and community, at this time of intense personal crisis. Patients undergo a standardised ritual of 'depersonalisation' and become a numbered 'case' in a ward full of strangers. The relationship of the health professionals with their patients is often characterised by distance, formality, brief conversations, and often the use of professional jargon.[22]

Some of the attributes of the professional arena are similar to those found by Gessler et al.[23] They described the healthcare delivery by healthcare professionals in CHCs as being characterised by brief encounters with doctors or the hospital staff (often less than 5 min), with the patient feeling confused and lonely in a foreign environment. Gessler et al.'s[23] study was based on experiences at CHCs, while the professional arena, which is a sub-model of Kleinman's model,[2] is based on experiences in hospitals. There are similarities in both models, namely:

1. Consultation happens away from the home, where illnesses are first declared.
2. Consultation happens away from family members who usually give support in indigenous consultations.
3. Time taken with the person in both areas is brief and rarely includes the home or community.

Atkinson et al.'s[24] study noted the importance of interpersonal aspects of the patient–professional relationship, such as amount and clarity of information regarding the condition of the patient,

bedside or chairside manner during consultation, similarity of socio-demographic backgrounds and the extent to which the patient can express opinions. A better patient–professional relationship was more positively associated with satisfaction about health or treatment outcomes. In other words, Atkinson et al.[24] found that user satisfaction is an important outcome in its own right because it predicts patient compliance with treatment, re-attendance at the clinic and even improvement in health status.

User satisfaction can be assessed in the communication patterns in the patient–professional consultation, relying on, *inter alia*, factors such as information transfer, user involvement in decision-making and reassurance about the patient's condition. These assessment indicators are important to compare and plan different ways of organising or providing healthcare.

According to Myerscough and Ford,[15] most people who are unwell look to the doctor for help, advice or reassurance, and in doing so assume a dependent role as a 'sick person'. This submission to their medical attendant is a result of feelings of uncertainty and fear that come with illness. This may promote a paternalistic attitude, which the doctor must guard against, as it could lead to overlooking the patient's needs and concerns. Others find that being sick is the only way of gaining the attention and concern of those around them. These attention seekers enjoy recurrent ill-health year after year.

African indigenous health belief models

As previously mentioned, the African representation of illness, treatment and prevention is largely dependent on the culture that one embraces. Maelene[3] remarks that:

> Traditional Africans do not believe in chance, bad luck or fate. They believe that every illness has an intention and a specific cause, and in order to combat the illness, the cause must be found and counteracted. In the quest to understand illness, the questions 'Why?' and 'Who?' are uppermost in the minds of traditional Africans. (p. 15)

It could be interpreted as a positive and exciting way of thinking if interpreted within the asset model of health promotion and the willingness of health educators to work with traditional African people in developing the links between the biomedical approach and the traditional African approach. According to the African tradition, proximate (immediate) as well as distal or ultimate causes of ill-health require treatment if a disease is to be cured.[3,4] Diseases manifest themselves not only as physical symptoms, such as fever or pain, but also in mystical disturbances of the blood, commonly described in terms of impurities.[4] To treat proximate causes and physical symptoms, people may consult medical personnel and/or traditional healers for appropriate remedies. However, treatment must also be sought for the ultimate cause of a disease. These mystical conditions belong to the spiritual domain, which only traditional healers or diviners can heal through their insights and therapies.[4]

Prevention of illness happens at two levels: societal and individual. At the societal level, the belief that violations of social, religious or sexual codes of conduct will bring about disease – either through the actions of other people or through ancestral intervention – constitutes a powerful mechanism for ensuring social cohesion and stability.[12,14,15] On the other hand, at the individual level, malevolence can target an individual, for example, through infertility, high rates of infant mortality or adult sterility. If mystical forces dominate human experience, then believing that these are rational forces gives a sense of order to unfortunate events. The general breakdown in traditional family life accompanied by a prolonged absence of the head of the household can bring illness to that household. Thus, to avoid being possessed by illness, one needs to observe stricter social and moral codes.[3,4]

These representations of illness have been carried into the current, modern world. As an example, around 1910, the Zulu people of South Africa believed in *indiki* and *ifufunyane* (certain forms of psychological disturbances), which they associated with the disruption that migrant labour (and high-risk occupations

such as construction work and underground mining) brought to families. When migrant labourers were killed at work, their remains were buried close to the working area and not at home. Consequently, there was a belief that their spirits were too far away to benefit from sacrifice, and as ancestors they were unable to monitor the daily functioning of their families. Thus, it was believed that these spirits would possess a live Zulu man in the mines in a last-resort attempt to return home with him and be able to assume an ancestral role within the family; hence, the possession of these Zulu men with *indiki* or *ifufunyane*.[4]

Despite the perception by missionaries, doctors and educators that they were entering a zone of pure ignorance regarding health matters, Liddell et al.[4] maintain that illness theories in the sub-Saharan African cultures had readily accommodated some of the biomedical concepts of the 20th century. However, the fundamental principles on which they are founded lay much further back in history. Thus, Liddell et al.[4] present three types of categorisation for illness in sub-Saharan African cultures:

1. Type 1 illnesses have no discernible moral or social cause. These tend to be *minor ailments* such as rashes and colds. These are the only illnesses that occur by chance and for which causes are not sought.
2. Type 2 illnesses are modern diseases that can be contracted by people anywhere in the world and were first introduced into Africa by European settlers.
3. Type 3 diseases are those that only African people contract and to which all Africans –regardless of tribal or geographical origin – are vulnerable.

As previously explained, any attempt to determine the causes of illness would only relate to illnesses of types 2 and 3, as these can usually be related to discernible proximate and ultimate causes. The first approach would be to look at the condition within the proximate dimension, for example, infections and contagion caused by pollutants. This understanding predates medical models. Next would be to search for the ultimate cause, looking

at why a disease was contracted by a particular person. Liddell et al.[4] provide the example of a mother who can gauge that the cause of her child's diarrhoea might be flies that would have settled on the child's food (proximate cause), but she will also want to establish who sent the flies (ultimate cause). Liddell et al.[4] highlight three types of causes that are used to explain ultimate causes:

1. *Contact with pollutants*: Pollutants often originate from other people's bodies and could include semen, menstrual discharge, vaginal secretions and blood, and might lead to infections, such as HIV and AIDS, which probably can lead to death. These inherently polluting discharges are equally dangerous to both healthy and sick people; thus, people need to fortify themselves from contamination by maintaining strict moral codes and observing protecting rituals.
2. *Witchcraft and sorcery*: Illness can be inflicted by people who have been offended by the victim. Failure to honour filial obligations, violence or other forms of uncooperative behaviour risk creating a level of offence that can lead kin or neighbours to seek redress through witchcraft.
3. *Ancestral vengeance or punishment*: The survival of ancestors in the spirit world depends on their being accorded regular attention from their living offspring. This attention is manifested in rituals, sacrifices, avoidance of taboo and high standards of social behaviour. When these requirements are not met, illnesses can be sent from the ancestors as a warning or punishment.

Together with the emergence of new diseases, new epistemologies have usually been incorporated into the culture if they resonated well with the old social mores. So, for example, the Christian belief that epidemics are sent by God as a punishment for sins resonates well with indigenous beliefs about the ultimate causes of illness, except that ancestors and witches are now joined by a Christian God.[4] In this way, indigenous beliefs about the ultimate causes of illness have had ample opportunities to remain intact.

It is not unusual for people to consult both traditional healers and medical doctors about both proximate and ultimate causes of disease. In South Africa, there are more than 300 000 traditional healers, 15 times the number of medical doctors.[13] In Nigeria, there is evidence that people depend more on traditional healers for treating HIV and AIDS than they do for any other disease. The rationale is that sexual matters are the special remit of traditional healers.[3,4] In addition, traditional Africans believe that traditional healers would be able to answer such questions as, 'How is it possible that two men exposed to the same woman do not both become infected and affected?' According to Maelene,[3] to blame external factors such as witches and sorcerers for HIV and AIDS has two functions. Firstly, it prevents feelings of guilt and alleviates anxiety and, secondly, it provides people with answers that science cannot give.

The view of traditional Africans has serious implications for health education and the prevention of illnesses, especially those related to sexuality such as HIV and AIDS.[3,4] The traditional view of sexuality in African culture is that women should get married and have children, and amongst those children there should be a son, failing which the man will find another wife to try his luck for the birth of a boy. To the African family, a boy means an extension of the family and a way of keeping the family in touch with the living and the dead.[3] This attempt to have a son might continue with the extension of wives, until a male heir is born.

In a traditional African family, having children is extremely important if Africans are to prosper (in terms of land and ancestors) as a whole, as a man's wealth is linked to the growth of his tribe. Maelene[3] argues that once Western AIDS counsellors understand the issue of immortality in traditional African terms, they might start to understand why polygamy is practised in many African cultures. They might even start to understand why convincing Africans to use a condom is so difficult, and why African women insist on having children, even when they are HIV-positive.

While Western health educators might frown upon the prevalence of polygamy in African societies, polygamy often

serves to reduce infidelity, prostitution, sexually transmitted diseases (STDs) and HIV. Later, Mji,[5] in her PhD thesis, ascertained that polygamy in Xhosa families was also used as a form of contraception.[3,5] In some African cultures, there are certain times when sexual intercourse between a husband and wife is prevented, for example, while the woman is pregnant or during lactation until weaning (usually when the child is between 3 and 4 years of age). However, the African man believes that sexual engagement and the release of semen is a healthy phenomenon in which a man should frequently engage. African men are very concerned that their newborn infant should thrive and so he does not expect to have sexual interactions with the mother, as this is seen to compromise the development of the child, for example, leading to stunted growth. In addition, there is also a chance that the mother would become pregnant again before the child is fully grown, thus further jeopardising the growth of the child. So, instead of consorting with outside partners, the man remains within the circle of his wives.[3,22]

Liddell et al.[4] explain that when a man receives traditional medication for an STD and other related illnesses such as HIV and AIDS, there is a belief that this medication will clean his blood and that the impurities will be released via bodily excretions, including semen. Thus, during this period, the man will not want to sleep with his wife as his semen will make her sick and could cause a further spread of the disease. He thus chooses to sleep with somebody he cares for less.

Liddell et al.[4] and Maelene[3] caution Western-trained health educators not to label the reluctance to wear condoms as promiscuity, permissiveness or a lack of moral and religious values. These labels simply demonstrate a lack of understanding of the African philosophy underlying sexuality, as well as a disrespect for African values. The challenge is not to blame but to develop an understanding of hidden cultural beliefs. Some of these beliefs about condoms include the following:

- Condoms block the gift of God. Rwandans believe that the flow of fluids involved in sexual intercourse and reproduction

represents an exchange of the gift of self, which they see as very important in a relationship.
- Condoms undermine the central tenet of traditional African thought, namely, that life-enhancing forces are expressed through fertility. Abstinence, too, is a challenging concept as it denies the opportunity for sexual release, which is thought to be essential for health, at the same time stifling the expression of fertility.
- Condom use is interpreted as wasting and showing disrespect for a treasured resource, namely, sperm.
- Condoms are believed to prevent the ripening of the foetus. The South African Zulus, for example, believe that semen is needed to form or ripen the growing foetus in the womb, and that condoms interfere with the process of natural foetal development.[3,4]

Maelene[3] calls upon all healthcare practitioners and educators, especially those working in rural areas, to take these health beliefs into consideration in their health education programmes. This notion is supported by Zonke,[13] Gessler,[23] Mlenzana and Mji[26] and Bührmann[27] in their studies of CHCs in peri-urban environments in South Africa, where they found that people alternate between using Western and traditional medicines.[8,9,10,11,28,29] In fact, medical doctors in Southern Africa acknowledge that traditional healers carry most of the burden for treating diseases like HIV and AIDS.[4]

It is interesting to note that the HIV and AIDS epidemic has exposed the huge gap between traditional medicine and biomedicine in terms of understanding and responding to illnesses. Many of the biomedical prevention messages about HIV and AIDS are in direct contradiction to African beliefs about fertility. This threatens the seamless and functional relationship between cause, treatment and prevention valued by traditional Africans. However, there is a need for the two schools of thought to come closer before another epidemic emerges. Medical doctors tend to practise from a distance and are usually overburdened with too many patients, while traditional healers are more likely to pay the patient a home visit, especially when the illness is serious, such as HIV and AIDS.[4] In addition, in the

eyes of the community, traditional healers have more authority than nurses, who are usually only responsible for palliative care. Green, cited in Liddell et al.,[4] sees traditional healers as:

> [*P*]riests, religious ritual specialists, family and community therapists, moral and social philosophers, teachers, visionaries, empirical scientists and perhaps political leaders in addition to being healers in the more restricted Western sense. (p. 36)

This multiplicity of roles played by traditional healers makes it difficult to ascertain what the continuing reliance on them signifies, and we cannot simply assume that the reasons people consult them have remained the same over time. Green (cited in Liddell et al.[4]) suggests that traditional healers offer a more comprehensive approach to disease. This concurs with Liddell et al.'s[4] view that traditional healers show greater insight into people's beliefs and thus offer greater flexibility than Western-based healers. For example, many traditional healers tell their persons that HIV is an infection brought about by evil spirits and that the use of a condom can trick these spirits. Others have even put up dildos as a permanent feature in their places of worship.

Nsameneng, cited in Liddell et al.,[4] argues that African indigenous beliefs have not been extinguished by colonial imposition or Western adaptations. The ongoing prevalence of traditional healers in modern society is itself evidence in support of the persistence of indigenous beliefs about illness. However, social scientists are reluctant to explore indigenous knowledge as they fear that they would be seen to be examining work that is outdated and belonging to another era.[4]

Traditional healers are not only diviners and herbalists but also include the older people who regularly use indigenous methods and strategies in health management. In the short term, ignoring IHK beliefs about illness, which African societies have long construed as essential for their survival and well-being, seems to be counterproductive to the management of illnesses in Southern Africa[3,4] and to the development of culturally grounded health prevention programmes.[30, 31]

It is interesting to note that in South Africa, in 2012, a national professional council for traditional healers was in the process of obtaining recognition from the government for their treatment methods.[32,33]

African approaches to healthcare in the home setting

In any African society, the home is the heart of everything. It is where things start and it is where things end.[32,33] According to the Reader's Digest Association of South Africa,[34] this concept of home dates as far back as the Iron Age, when African people used all available resources to survive. In those times, life was simpler, and natural plant resources were the main source of medicinal, cultural, religious and other needs.[22] Older people, specifically the older women, played an important role in maintaining stable health within the home setting.

People in rural settings relied on cattle farming and natural vegetation for their survival and livelihood.[34] The home was where creation and invention happened, where new technologies were developed and where natural resources were used to treat health problems.

Mtyaphi[35] argues that the older women were accorded recognition and respect in their families because of their prior knowledge and experience, and their wisdom was utilised effectively in all instances in the home, including for the management of health issues. They reared the grandchildren and passed on the beliefs and culture of the community, thus leaving the second generation free to become the productive generation.[22]

In the Xhosa tradition, a girl grandchild acquires knowledge predominantly from her grandmother. When she marries, she moves to her in-laws and is integrated into their household as an apprentice to her mother-in-law.[22] In this way, she absorbs the culture of the new household, including their knowledge, such as the use of herbs. Although she still holds the knowledge from her

grandmother that she came with, she practises it silently, only bringing it into the open to support her mother-in-law during critical incidences. When her children are born, they fall under the supervision of her mother-in-law and she becomes the observer and learner, validating the knowledge she learnt from her own grandmother.[22]

Once a married woman assumes the role of a grandmother, she would feel more confident about supporting the family, as her knowledge, experience and wisdom would have been validated again and again, as being important in the day-to-day events of the family setting.[22,27,31] Older women monitor the health of family members.[31] According to Bhat and Jacobs,[35] if a family member falls ill, the older woman watches the person's behaviour, examines the patient, decides which herbs could be used for treatment and later prepares a treatment mixture using available plants. Grandmothers (*Makhulu*) have a sense of responsibility when fulfilling their role in maintaining stable health in the family. They have the patience to help the sick person and a passion for what they are doing.[13]

Murdock[37] maintains that the older woman is like a guide to the mysterious realms of the feminine. She is remembered by the younger women as a safe haven, a source of nourishment and a caretaker during illness. She embodies the qualities of feminine insight, wisdom, strength and nurturance, which may be missing in daily human life when she is not part of this system. The older woman has practised and sharpened her qualities and skills as a caretaker and nurturer earlier on in her development. As women bring life into the world, they are expected to develop skills on how to nurture and care for this life through to adulthood.[37] From conception until birth and through the growing years, society expects women to have the wisdom of caring.[38]

Bhat and Jacobs[36] and Mtyaphi[35] opine that the home is the place where healing first occurs. In the patriarchal African society, women are first expected to give birth to healthy sons and then maybe also to daughters. Banda[39] asserts that if a child is born

with disabilities, the blame is cast on the mother because she must have done something wrong for this to happen. The very partner who is also a party to the making of this child is the first one to distance himself from the situation. Stories of children with disabilities who have been killed at childbirth litter the history of the birth of children, and are grim reminders for the expectant mother of the high expectations that she should give birth to a healthy child. Even today, in the more enlightened times in which we live, in countries such as Ghana, women resort to killing and throwing away their infants with disabilities to save themselves from blame and shame (key informant from Kwame Krumah University of Science and Technology, Kumasi, Ghana, 2008). Knowing and understanding the lofty goals of caring and nurturing, women have had to learn how to achieve these goals with the support of other, and often older, women.[40]

Through experiential instruction from their own grandmothers and other older women around them, women have developed, and continue to develop, various strategies to strengthen the home, including its healthcare needs. Through trial and error, they have used herbal remedies to heal their family members and to assist other families in need.[39]

This is the situation that the first colonisers found amongst the Xhosa people.[31,32] They came to the colonised states, carrying their religion and Bible, with their European and Western world notions of education and scientific healing.[31,32] During this period, not only were the indigenous healing abilities and healing spaces taken away from the home, but also the home's multiple roles as the first creator and nurturer of knowledge, culture, beliefs and productivity were all siphoned into institutions designed to build an industrial empire in which women had little say.[38]

Zonke[13] describes the home as a complex terrain in which closely related family members live and interact. It is an organisational structure, with its own hierarchy, relationships, organisational norms and life, which is obvious and sometimes hidden or unspoken.[31] The home is also the place where personal and private matters, such as

illnesses, are declared and contained, and the social determinants of health are practised and played out.[13,26]

Fry and Hasler[18] state that the original setting for most PHC is probably the patient's own home, and that this tradition has persisted in some countries, although it is becoming less common. As already stated, Fry's observation is borne out in the traditional Xhosa home, where the female older person holds the highest position in the hierarchy regarding the management of health problems. The advantages of this for the patient include concerns regarding health status, the avoidance of discomfort and the cost of travelling to a PHC unit, as well as a reduction in the real or imagined risks of catching infectious diseases from other patients. The disadvantage for the patient is that he or she may be examined and investigated less thoroughly in the home situation, or that more serious conditions may be missed. Fry seems to suggest that only MHAs should be managed at home, a view in contradiction with that of the group of elderly persons residing in Khayelitsha and Philippi who believe that when health facilities are far away and one is faced with a sick individual within the home, one does not differentiate whether it is a minor or major illness; the priority is to relieve pain and suffering.[13]

Health problems commonly managed by alternative or unconventional methods

Eisenberg et al.[40] note that in the United States, unconventional medicines and therapies (i.e. not biomedical) are used significantly more often amongst people with college education (44%) than amongst those with no college education (27%), and was significantly more common amongst people with an annual income above $35 000 (39%) than those with a lower income (31%). The vast majority (83%) of people also sought treatment for the same condition from a medical doctor; however, 72% of the respondents who used unconventional therapy did not inform their medical doctor that they had done so. Unconventional medicines were also

more commonly used by people living in the West (44%). In 1990, people from the United States made 425 million visits to unconventional therapists as compared to 388 million visits to PC physicians. Expenditure related to unconventional therapy in 1999 amounted to approximately $13.7 billion, of which three quarters were paid out-of-pocket ($10.3bn). The conclusion that Eisenberg et al.[40] came to is that medical doctors should ask patients regarding the use of unconventional therapy whenever they obtain a medical history.

While health professionals in CHCs are chastising patients for using methods of healthcare other than conventional methods, it would appear that in the United States – the very country which is used as the yardstick for best practice – patients, especially those with a college education, are opting for unconventional treatments. Mishra et al.[41] and Mugisha et al.[42] noted that there are many reasons that influence patients to go outside conventional health facilities. Some of these are related to poverty and not being able to pay the costs of conventional care, while others are confident that they can manage their illness at home.

Other than chastising patients, would it not be better to try and understand why they opt to utilise unconventional therapy and home medications? Table 2.1 presents the medical conditions that most commonly prompt patients in the United States, the Samoan Islands and South Africa to seek unconventional healthcare.

Eisenberg et al.'s[40] research was undertaken mainly amongst American citizens and is slightly different from the research of Mishra et al.[41] and Puckree et al.,[43] whose participants were drawn from underdeveloped areas and regions. Eisenberg et al.'s list,[40] as shown in Table 2.1, contains mainly chronic diseases, while the other two lists contain both chronic and acute conditions. Puckree et al.[43] express general concern about the medical conditions for which participants use unconventional medicine, as some of these conditions are life-threatening. This raises the question, do people want to visit unconventional healthcare providers, or is there no alternative as health services are unavailable to manage

BOX 2.1: Medical conditions managed using unconventional healthcare.

Medical condition[a] (The United States)	Percentage reporting	Medical condition[b] (Samoans)	Percentage reporting	Medical condition[c] (South Africa)	Unconventional versus physiotherapy visits
Back problems	20	Musculoskeletal (acute and chronic)	30	Chest conditions	124/150
Allergies	16	Gastrointestinal	18.7	Poisoning	225/0
Arthritis	16	Neurological	16.6	Venereal disease	167/24
Insomnia	14	Dermatological	10.6	Fracture	127/202
Sprains or strains	13	Pallor, drooling and swelling	8.2	Hypertension	175/3
Headache	13	Obstetric (pregnancy massage)	3.1	Headache	4/4
High blood pressure	11	Samoa spiritual issues	7.2	Stroke	205/139
Digestive problems	10	Respiratory (asthma, shortness of breath)	2.2	Backache	171/133
Anxiety	10	Psychiatry and behavioural	1	Oedema	8/98
Depression	8	Fever, malnutrition, influenza	0.6		

Source: Mji.[25]
[a]Eisenberg et al.[40]
[b]Mishra et al.[41]
[c]Puckree et al.[43]

these conditions? Some illnesses, such as poisoning, are acute and life-threatening; therefore, one would presume that people would use whatever health assistance is immediately available. Chronic problems, such as hypertension, and anxiety-related problems also feature strongly Box 2.1. These problems are never easy to manage medically and have no instant remedy. They also require some form of accountability from the patient. It is important to note that in Puckree et al.'s[43] list, the unconventional management of venereal disease scores highly. Could this be related to the fact that Puckree et al.'s[43,44] participants were

mainly indigenous Africans in whose culture venereal disease is linked to infertility, which is related to sorcery, and therefore beyond the realm of modern healthcare? In addition, as earlier mentioned by Maelene[3] and Liddell et al.,[4] fertility is important within the African tradition.

Mlenzana and Mji[26] and Zonke[13] comment on how difficult it is to define minor ailments, as what often initially appears to be minor can become complicated and develop into a major ailment. Welle- Nilsen et al.[44] define MHAs as back pain, burns, common cold, minor cuts, stomach ache, insect bites, nosebleeds and rashes.[44] McWhinney[45] and Barber[46] further describe minor ailments as ranging from back pain to diarrhoea and wind. Table 2.1 summarises McWhinney's[45] and Barber's[46] minor ailments and provides the Xhosa word for each ailment.

The majority of the so-called MHAs mentioned in Table 2.1 would rarely cause immediate death, unlike some of the illnesses mentioned in the lists of Mishra[41] and Puckree[43] in Box 2.1. McWhinney's[45] and Barber's[46] list, which the researcher regards as also containing acute ailments, differs from Eisenberg et al.'s[40] list that includes more chronic ailments. Having said this, the illnesses mentioned in Table 2.1 still require close monitoring by a health team at the primary level of care.

TABLE 2.1: List of MHAs.

Minor ailment	Xhosa word
Back pain	*Umqolo obuhlungu*
Common cold	*Ukukhohlela*
Conjunctivitis	*Amehlo abuhlungu*
Constipation	*Ukuqhineka*
Diarrhoea	*Isisu esihambisayo*
Earache	*Indlebe ebuhlungu*
Headache	*Intloko ebuhlungu*
Sore throat	*Umqala obuhlungu*
Toothache	*Izinyo elibuhlungu*
Vomiting	*Ukugabha*
Wind	*Umoya*

Source: McWhinney[45] and Barber.[46]
MHAs, minor health ailments.

TABLE 2.2: List of MHAs that persons listed as treatable at home.

Ailment	Number of persons (*N* = 100)	Percentage
Headache	39	39
Stomach ache	28	28
Fever	15	15
Cough	10	10
Diarrhoea	9	9
High temperature	5	5
Tuberculosis	4	4
Vomiting	3	3

Source: Fink.[16]
MHAs, minor health ailments

Mlenzana and Mji[26] explored the perceptions of 100 participants residing in Khayelitsha and Philippi regarding MHAs and attending CHCs in the area. Table 2.2 lists the nine ailments most commonly mentioned by participants, which could be treated at home.

Four of the MHAs listed in Table 2.2 are similar to the MHAs mentioned by patients in Box 2.1 and are also similar to McWhinney's[45] and Barber's[46] list in Table 2.1. Mlenzana and Mji[26] were concerned that tuberculosis (TB) formed part of this list, as it requires medical attention, including close monitoring of regular and correct drug compliance, as well as the patient's response to medication. Mlenzana and Mji[26] explain that in Khayelitsha and Philippi there are home-based carers who monitor TB medication in the TB patient's home and, based on this, participants may have a perception that TB can be treated at home. She warns that patients could receive confusing messages regarding the right approach to this curable disease, which requires close monitoring during the entire course of treatment. She recommends that the perception that TB is a MHA should be further investigated within the TB management strategies, at the community level.[26]

It is of further interest to note that when Mlenzana and Mji's[26] 100 participants were examined by doctors at the CHC, the common diagnosis was that they had MHAs. In further interviews with these participants, Mlenzana and Mji[26] discovered that they

also reported other serious illnesses, such as kidney problems, arthritis, epilepsy and uterus problems. Mlenzana and Mji[26] remark that this is a cause for concern and wonder how these serious conditions managed to slip through the hands of both doctors and the CNPs. They quote Malcolm,[47] who raises concerns about the amount of consultation time that GPs have to spend with their patients. Malcolm[47] claims that the maximum time with a patient is 10 min during which the general practitioner is expected to listen; take an accurate history; explore the patient's ideas, beliefs and concerns about their problems; carry out an appropriate examination; arrange tests or investigations; and discuss and agree on a management strategy and safety net. This time constraint might be exacerbated by overcrowded CHCs. The risk of misdiagnosis, which could occur because of the limited time, is high, and as a result, Malcolm[47] has decided to increase the consultation times in order to better assist patients.

Mash's[28] concern regarding the nature of overcrowding in CHCs has already been mentioned. They note that amongst a sea of patients regarded as presenting with MHAs, there might well be patients with more serious ailments who might be either misdiagnosed or handled in a superficial manner. Table 2.3 presents the top 10 ailments mentioned by the 100 participants who were interviewed by Mlenzana and Mji[26] regarding their ailments.

TABLE 2.3: List of top 10 illnesses mentioned by participants.

Top 10 illnesses	Number of persons	Percentage
Fever	19	19
Stomach ache	12	12
Cough	10	10
Chest pain	9	9
Rash	7	7
Backache	6	6
Discharge	6	6
Sores or wounds	5	5
Pimples	4	4
Diarrhoea	4	4

Source: Mlenzana and Mji.[26]

Four of the top 10 ailments in Table 2.3 are also listed as MHAs in Table 2.2 and in Zonke's study.[13]

In Zonke's[13] study with 36 older people residing in Khayelitsha and Phillipi, a comprehensive list of health ailments that participants mentioned could be managed at home was generated. They disagreed with the suggestion that their home management strategies were appropriate for MHAs and maintained that in the past, the home was expected to contain all illnesses (minor and major) because of scarcity and inaccessibility of healthcare services in rural areas. Table 2.4 provides a combined list of illnesses mentioned by the older participants in the four focus group discussions (FGDs) that could be managed at home.

It is also important to note that the older women who were part of Zonke's[13] study had left the rural areas approximately 20 years ago and were currently living with second-generation families in the peri-urban area of Khayelitsha. Here, they were not given free rein to practise their healing vocation as the second generation uses CHCs for healthcare services, even for those ailments that the older people regard as minor. Clough[9] discusses how women repress their knowledge of healing to a preconscious level if they are not given space to continue to practise this healing vocation freely. Hence, it is assumed that these older women in Khayelitsha were experiencing a similar situation. Although they provide a list of ailments that they believe are manageable at home, there are other ailments in this list that Zonke[13] perceives as being too serious for management at home.

TABLE 2.4: Common MHAs mentioned in all four focus groups.

English version	Xhosa version
Common cold and flu	*Ukhohlokhohlo*
Chest pain	*Ihlaba*
Earache	*Indlebe ebuhlungu*
Headache	*Intloko ebuhlungu*
Mumps	*Uqwilikana*

Source: Zonke.[13]
MHAs, minor health ailments

For the current study, it was important to investigate how different the list of health ailments generated by the older Xhosa women residing in peri-urban Khayelitsha was from that generated by the older Xhosa women residing in the rural Eastern Cape. The latter are still regarded by their families as key decision-makers in health matters in the home situation. Some have the role and responsibility of being overseers of their grandchildren, while the parents work in the cities, and yet others have become mothers and fathers to grandchildren whose parents have died of HIV and AIDS. So they have little time for assuming an overseeing role with regard to the overall health needs of these children.

Since 1994, PHC was rolled out throughout South Africa, including the rural areas such as the Eastern Cape. It was thus expected that this would provide people with general access to PHC and health services, and that this would impact what is managed in the home and what is managed at public health centres. This study proposes the integration of the two systems, that is, the indigenous and the Western health systems, with the older people playing a key role in the management of MHAs in the home setting. Having said that, however, UCT [13,26] has already extended a caution regarding treatment at home and giving the older women a pivotal role in the management of minor ailments. Before this happens, they caution, dangerous traditional or unconventional methods need to be identified and the older women need to be discouraged from using these.

Dangerous alternative and/or unconventional methods

Abrahams et al.[29] argue that advocates of Western medicine commonly attempt to show how dangerous indigenous health methods are.[3,4,48,49,50,51,52,53] Mkhize[49] accuses the Western industrial world of trivialising indigenous knowledge, including IHK, calling this a subjugation of knowledge, which is close to brainwashing and is driven by a neo-colonialist agenda. Abrahams et al.[29]

suggest that in keeping with calls for an African Renaissance, there is also the need for a shift in emphasis from exploring what is harmful in IHK to developing a greater understanding of IHK. Many researchers have called on scholars to study, validate and transfer indigenous knowledge (ethno-science) for the sake of younger generations.[6,8,13,22] There is a fear that the carriers of indigenous knowledge, including IHK, will die out without having transferred their knowledge to younger generations because of the breakdown of family units and the migration of younger generations to cities. There is the danger of losing this reservoir of knowledge.[3,4,48,49,50,51,52,53,54] Another challenge which relates to Abrahams et al.'s[29] concerns is the stagnation or lack of progress of indigenous knowledge. Since the earliest colonisers interpreted the IHK of the Xhosa people as the darkest knowledge, it has become hidden and is practised in secrecy, thus limiting its development.[55,56,57] Katzenellenbogen[58] maintains that applied knowledge requires verification during which mistakes can be and are made. The researcher, herself being a health professional for the past 20 years, remembers many slips that occurred between the patient and the Western healer. During these periods of slippage and readjustment, many lessons were learnt. Unfortunately, in South Africa, IHK has not been afforded the terrain to be practised openly, to make mistakes and to learn from those mistakes so that there can be further development.

Having said that, it is important to share that one of the conditions of the Human Research Committee for this study of IHK was that, should any dangerous substances or approaches be identified, they would be discouraged. In this review, the researcher would therefore like to briefly discuss some of the concerns raised by other researchers regarding potentially dangerous IHK practices.

Abrahams et al.[29] explored indigenous healing practices and self-medication amongst women in Cape Town, South Africa. They conducted 103 interviews with women in a primary antenatal setting. Roughly two-thirds of the Xhosa-speaking women followed IHK for themselves and their babies and reported having

done this with previous pregnancies as well. Not being given medication from a Western healthcare facility was perceived to be tantamount to not being given any care at all, and it was this that influenced the women's choice of selecting another health provider. Many women believed that pregnancy was a 'delicate' time when a woman has to deal with a myriad of problems. These problems range from direct sorcery originating from neighbours or the girlfriend of the child's father who might have a grudge or be jealous to ancestry neglect so that an appeasement of ancestors might be required. Some of these problems could lead to the death of the mother or the child. As illnesses originating in sorcery or appeasement of ancestors are seen by traditional people as being beyond the scope of Western-trained practitioners,[8,13,15,50,51] these traditional women consulted with and used indigenous healers during pregnancy to strengthen themselves and the foetus, and also after childbirth.

Bland, Rollins, Broeck, Coovadia and the Child Health Group,[59] who studied the use of traditional medicine in the first 3 months of pregnancy amongst rural South Africans, have challenged the IHK approach. They suggest that although many illnesses may be successfully managed at home using IHK, these remedies are not without their own hazards. They mentioned that the use of enema in KwaZulu-Natal has been associated with severe metabolic or organic dysfunction, including the acute onset of respiratory distress, abdominal distention and hypotonia. Electrolyte disturbances may be caused by water enemas and mortality because of renal and hepatic failure. They concluded that treating newborns or infants at home may delay seeking professional help for potentially life-threatening conditions such as gastroenteritis. Furthermore, giving non-prescribed medicines precludes compliance with exclusive breast feeding (EBF) as defined by the WHO.[14] Exclusive breast feeding entails giving the infant no food or drink, not even water, apart from breast milk – including expressed breast milk – with the exception of drops or syrups consisting of vitamins or mineral supplements.[14]

Niehaus et al.[60] explored the diagnosis of schizophrenia and other psychiatric disorders in relation to the culture-bound *ámafufunyane* and the culture-specific event of *ukuthwasa*. Both terms are used by Xhosa traditional healers to explain aberrant behavioural and psychological phenomena. According to Neihaus et al.,[60] there is an apparent overlap between these two conditions and schizophrenic symptoms. Although *ámafufunyane* seems to have characteristics similar to *ukuthwasa*, *ámafufunyane* carries a far more negative connotation and is generally used to describe a young person with schizophrenic symptoms. *Ukuthwasa*, on the other hand, is assigned to married people and is seen in a far more positive light. The concern of Neihaus et al.[60] was that, although these two conditions have similar symptoms, intervention with *ukuthwasa* might be delayed because of the way it is defined and seen in a more favourable light. They concluded that the positive connotations associated with *ukuthwasa*, as opposed to the more negative connotations of *ámafufunyane*, may have implications for the treatment and prognosis of schizophrenia and needs to be clarified.

The study by Niehaus et al.[60] coincides with a study by Mbanga et al.[61] on the attitudes and beliefs of Xhosa families towards schizophrenia. They found that although 88% of Xhosa families used psychotropic medications, 32% of this group believed that schizophrenia could be cured by traditional healing methods, and 30% used traditional rituals. Niehaus et al.[60] concluded that a number of worrying perceptions exist amongst patients and their relatives; for example, some believed that there was cause for concern only when the patient defaulted for over a month in taking psychotropic medication. They warned that clinicians who work with Xhosa-speaking patients with schizophrenia and their families would do well to be aware of traditional attitudes and beliefs towards this illness and to make an effort to determine their explanatory models. They further asserted that psycho-educational programmes need to address such explanatory models and that clinicians need to negotiate a shared biomedical model, which they perceived is likely to foster a therapeutic alliance and promote adherence to treatment.

Dagheir and Ross[62] studied the approaches used by traditional healers regarding the treatment of cleft lips and palates. Interviews were conducted with 15 traditional healers who each claimed to have been exposed to and have treated one to six persons with cleft lips. Most of the healers believed that cleft lip was caused by ancestors, spirits and witchcraft. Treatments included the use of thorns, needles, incantations; bleeding; sacrificing a goat or chicken; or the avoidance of certain foods, such as rabbit meat. Dagheir and Ross[62] cite Hammond-Tooke[63] who noted that many herbalists have a very good knowledge of many natural substances that have an authentic remedial effect. Seventy-three per cent of their participants maintained that they needed further input from Western approaches to improve their management skills of this condition. They concluded by recommending that sharing information on the treatment of cleft lip and palate needs to be done in a culturally sensitive manner.[62]

Lewis et al.[64] studied the oral health knowledge and practices of African traditional healers in Zonkizizwe and Dube, South Africa. They examined the self-reported knowledge and practices of 83 traditional healers and found that 48% of healers kept written records; more than 91% correctly recognised gingival inflammation, dental caries and oral candidiasis; and over 50% of healers referred patients to practitioners in the formal healthcare sector. The vast majority of healers gave oral health advice to their patients, and many of them gave specific toothbrush instructions. Forty per cent of the traditional healers gave patients *muti* (traditional medicine) to use as a rinse for the treatment of oral candidiasis, and 18% prescribed combinations of salt, snuff, glycerin, sugar and bicarbonate with which to rub or rinse. Two healers spoke of treating dental caries by removing the 'worm' which causes decay, and giving the patient *muti* to rub on the tooth and then having the patient inhale smoke. The authors expressed concern about information shared by traditional healers on how patients are treated by Western doctors. They maintained that patients often leave after consulting the doctors not understanding exactly what is wrong with them or how they should use the

prescribed medication. They are also scared to ask questions. Maelene[3] and Liddell et al.[4] recommend that traditional healers and Western health professionals should spend more time in collaboration to learn about their different cultural beliefs and practices.

Eshete[65] found that, in many parts of the developing world, a large proportion of fractures continue to be treated by traditional bone setters who are easily accessible and often have a good local reputation. There are usually no mainstream medical facilities and patients often travel as far as 300 km to receive specialist surgical attention. Many arrive on the back of fellow villagers, as road transport is rare. While many fractures heal properly with traditional treatments, bone setters are often unaware of the dangers of tight splinting, which can cause gangrene which eventually necessitates amputation. Eshete's[65] study found that in Southern Ethiopia, in a span of 1 year, 49 amputations were performed, of which 25 were the result of tight splinting by the bone setters. The traditional bone setters often use splints from bamboo or strips of wood that are tightly bound around the limbs, and occasionally also the joints. Unfortunately, these splints are not removed when pain increases, and thus a compartment syndrome with its complications or death of tissue and gangrene may follow. Death may result when complications such as tetanus and septicaemia set in.

Eshete[65] arranged workshops to assist the traditional bone setters to gain an understanding of the precautions to take with splinting, and to become more aware of some of the complications of bone setting. In the beginning, people were afraid to declare that they were in fact bone setters. Some feared that they would be stopped from practising their vocation, thereby depriving them of an income, while others feared purging. However, with the cooperation of local leaders and a 1-day training programme, Eshete[65] maintained that they have decreased the problems of gangrene from bone setting by 50%, and this also includes amputations that are related to bone setting complications. Thus, Eshete[65] concludes that the incidence of gangrene related to

traditional bone setting can be reduced with education and awareness.

Puckree et al.[43] consulted traditional healers regarding physiotherapy-related illnesses and reported that some patients visited traditional healers for conditions that were regarded as life-threatening, for example, chest conditions, poisoning, stroke and fractures. Other conditions for which patients visited traditional healers included a 'chesty chest' (chest with secretions), traditional vapour baths, heat therapy for body pain and massage with ointments, all of which are similar to physiotherapy modalities. Puckree et al.[43] concluded that despite the popularity of traditional healing, it has remained marginalised, poorly regulated and unsubsidised. The lack of subsidisation could cause a drain on the meagre resources of those rural families who lack access to health services and have to resort to consulting traditional healers, and for poor families who choose to visit a traditional healer.[43]

To conclude this section, it is important to mention that the decision to consult a traditional practitioner is not made lightly by patients and their relatives.[41,42] The majority of patients, when confronted with a medical problem that appears beyond the scope of home remedies, would prefer to first seek medical help when it is available.[14,66,67,68] However, some patients report that the type of medical care they receive is often unhelpful, and this is why they choose to see traditional healers.[13,66,67] There is a strong call for health professionals to be more empathetic, to give clear and consistent explanations about illness and treatment, and to refrain from criticising patients who have tried traditional medicine.[6,12,24,40] There is a call for Western healthcare and traditional healing to reconcile, with the hope that the veil of secrecy that exists regarding IHK and its practices will be lifted so that both sides could benefit from understanding each other's approach.[12,29] Ironically, when one examines some of the approaches used by indigenous healers, they are not far off from some of the initial approaches used by modern healthcare. Indigenous health knowledge has not been afforded the opportunity to develop, as it is practised in secret. Empowerment is

one of the key elements of PHC, and recognising the existence of IHK as an asset and helping it to develop would benefit both modern and traditional healthcare.

Concluding statement

This chapter began by presenting the 1948 WHO definition of health, which has been criticised for not being sufficiently comprehensive. The health definition of the indigenous peoples of the world was also provided, and it was suggested that the two health definitions should be integrated to bring about an overarching definition of health that includes insights from the indigenous peoples of the world.

Health belief models were described within Kleinman's[2] Cultural System Model, which covers the popular, the folk and the professional arenas. It was noted that rural South Africans swing between the three arenas because of a lack of availability of health services. The studies of Maelene[3] and Liddell et al.[4] were drawn on for an African review of health belief models. Maelene[3] explains that traditional Africans do not believe in chance, bad luck or fate. They believe that every illness has a specific intention and a cause. This was supported by Liddell et al.[4] in their description of three categories of illness in sub-Saharan African culture. Both authors emphasise the need to consider African beliefs and practices when dealing with rural Africans.

A description of the home was given, showing that it is the place where illnesses are declared and contained, with the older women being seen as those who ensure good health and contain ill-health. Problems commonly managed by alternative approaches were listed. It was also noted that in America, alternative approaches were used mainly for chronic illnesses, whereas in South Africa, some life-threatening conditions are treated with alternative approaches, such as snake bite poisoning. A question was raised as to whether alternative approaches were used because of the lack of access to health services.

Lists of what people perceive to be MHAs were presented; however, it was noted that it is difficult to classify MHAs because what is regarded as minor ailment today could easily complicate into a major health ailment within the next few days.

This chapter concludes with a brief on what could be regarded as dangerous alternative methods. It questioned some perceptions that IHK is dangerous, explaining that it has tended to be practised in secret and has lacked the opportunity of being researched and scrutinised. The study reminds us that some of the early biomedical approaches too seemed to be barbaric when compared to the new approaches that have replaced them. It would appear that there is a need to understand what IHK really is. At the centre of this IHK is the older women. Murdock[37] maintains that the older woman is like a guide to the mysterious realms of the feminine. She is remembered by the younger women as a safe haven, a source of nourishment and a caretaker during illness. Chapter 3 explores the cosmology of women as healers, including the historical perspectives that have given rise to this knowledge being wrestled from women, arguing that women's struggle for recognition for the contribution they make to the health of their families is similar to the struggle of indigenous peoples for recognition of their knowledges.

Chapter 3

Women as healers and indigenous knowledge systems and its holders: An intertwined epistemological and ontological struggle for recognition

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Introduction

This chapter addresses the author's brief reflection clarifying her stand on some of the aspects that are presented in the chapter. Firstly, I see myself as a health activist and see health as the main

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contributor to life. By bringing forward the historical perspective of women as healers, I am not saying that men do not play a role in contributing to health matters, but my intention is to highlight and propose balancing of power in all life spaces (as health is life), starting with the health fraternity. This proposition is also linked to the lens I use between indigenous knowledges and science, advocating for all knowledges to be respected.

It is with this balancing paradigm that international perspectives of women as healers, including the wrestling of the healing vocation from women's grasps, are explained; this is followed by the impact of wrestling of the health knowledge from women to create health institutions that lack a feminine voice; the need for a balanced healing environment underpinned with respect and human dignity for all knowledge holders is highlighted; the role of women, specifically the older Xhosa women, is explained; the link between IHK and this study, including Southern African IHK approaches, is given; and the need to research IHK is highlighted. The chapter ends with a concluding statement.

International perspectives of women as healers and the wrestling of healing vocation from women's grasps

Although this study explores the IHK carried by the older Xhosa women as healers in the home, it is important to show that there was a space and time in the Western world when healing evolved around what lies in the invisible space of the relationships humans have with one another and their regard for the non-living and living things of the earth.[1] In this cosmology, women were found at the centre as healers. During those ancient times, the reigning Western deities were feminine, bisexual or androgynous by nature. In this view of life, the vocation of a healer, particularly, is associated with the sacred, and the healing beliefs of any culture directly reflect the nature of their gods. Thus, colonising ministers

of religion, when they entered South Africa, especially rural areas such as Madwaleni, found it very difficult to accept the Madwaleni healing approaches, as the Madwaleni people's gods were rejected as pagan. Over and above this, it was challenging to find that women played a pivotal role in the indigenous healing domain. This perspective is not far off from the healing approaches of many indigenous peoples of the world.[2]

Achterberg,[3] Struthers[4] and Murdock[1] all opine that women have always been healers. Cultural myths from around the world describe a time when only women knew the secrets of life and death. Therefore, they alone could practise the magical art of healing. Achterberg[3] argues that the dissonance between women's talents and women's fate deserves closer attention, as it reflects the evolution of institutions that lack a feminine voice. The absence of balance in these institutions has perpetrated a crisis that now extends alarmingly through all levels of health: from the health of cells, tissues, the mind and relationships to the health of the environment upon which life itself is dependent. With the new order of transference of health, from the home to the institutions at that time, came that final common pathway whereby women were forbidden entrance to the institutions of healing as they evolved.[5]

Achterberg[3] continues to say that early scholars and scientists such as Descartes facilitated the development of theories that supported the separation between the body and the mind. According to Descartes, there was nothing included in the concept of the body that belonged to the mind, nothing in that of the mind that belonged to the body. The disciplines of medicine and science became the study of what could be physically realised; what could not be seen became the province of other disciplines. Descartes' work can be summarised as follows:

1. There is a certainty and knowability of scientific truth.
2. Mathematics is the key to understanding these truths.
3. The process of analytic reasoning – breaking something down into its smallest parts – will lead to ultimate understanding.

4. The universe is a physical thing, and all that it contains can be analogised to machines.
5. The mind and the body are separate entities.

The impact of the scientific revolution was dire for both women as healers and for nature itself. Taking mind and spirit out of nature made way for an objective vision – one ostensibly separated from the invisible realm. Like conception, pregnancy, giving birth and raising children, including taking care of the home, all elements that maintain health, as women's contributions in medicine and science, were ignored or trivialised.[5]

It was only in the 19th century that women started to awaken from the constraints forced upon them. Three events marked the attempt of women towards emancipating themselves from their exclusion from health matters:

1. the training of relatively a large number of women as physicians
2. the establishment of nursing as a profession
3. the founding of churches with a healing doctrine.

These groups of females were endowed with qualities of warriorship, strength, dignity and a sense of purpose. They had a clear vision of where they were going and their ideas projected into the far future.[3,5] They challenged the stereotype that women had no place in medicine and also wanted to act as a support system for other women when they were sick. They tended to be mainstreamed into the so-called less competitive environments, as even the women saw themselves as too vulnerable to stand on their own.

After 1900, and supported by medical reforms, the alliance of corporate power and money, medicine became increasingly masculine. This had a direct impact on health delivery. It became a space whereby the health profession, instead of being a caring profession, came to be seen as part of a class system, with the male figure at the helm. Most women were channelled into nursing. These reforms were followed by the building of medical institutions, and medical schools gained control of the clinical

experience of medical students, and the establishment of scientific laboratories in conjunction with the development of medical schools in Europe, especially in Germany, whereby coveted medical models were offered.[3] The question that needs to be asked is, 'Were all these models underpinned by respect for human dignity?', as it is believed that in these medical institutions this is the era whereby the human body was subjected to classification and the emerging of the body with disabilities that needed to be cast out of inclusion in participating in these institutions that were governed by perfection. Teachers and heads of departments were recruited from clinical practice, thus making teaching and clinical care secondary, with research at the top of what was required from a medical teacher.

The nursing profession was not the only women's health profession wrestling with the dilemmas imposed by the masculinisation of medicine. The end of the Second World War placed an emphasis on services for persons with disabilities, and professions such as physiotherapy, occupational therapy, and speech and language therapy within the rehabilitation field were born.[3] The so-called allied health professions, from the outset, emphasised submissiveness and conformity to the male-dominated medical profession. Achterburg[3] gives the example of therapists who pledged that they would walk in upright faithfulness and obedience to those under whose guidance they were supposed to work. Today, people working in these fields still face the very same challenges as nurses at advanced levels: They are more or less autonomous, have their own research base and refined clinical skills, and yet they must work under the auspices of a physician who knows very little of the work they do.

This masculinisation of health services is not isolated to health only. Previously in this book, we have seen health declared as a reserve for life, and the characteristics of health services were indeed to be found in the characteristics of general life in societies. Churches, industries and sport were utilising a similar recipe whereby males were at the top. Korten[6] and Brown[7] both

argued that we face developments specific to our time that tell us the empire has reached the sustainable limits of exploitation for both people and the earth. We have already seen the trauma we have subjected the environment to and the negative consequences of these actions, especially for people living in low-income countries, though they perpetrate minimal onslaught to the environment.

The impact of wrestling of health knowledge from women to create health institutions that lack a feminine voice

The absence of a female voice in key decisions pertaining to planet Earth is plunging the whole world into darkness and destruction (e.g. climatic changes, tsunamis, epidemics, wars, poor distribution of resources and major funding for weapons of mass destruction). Researchers worldwide are challenging and pleading with the world population to take note of this and respond to by resisting the present devastation. They quote what happened prior to the invasion of Iraq by the United States and its war on terror, namely, that up to 10 million people marched in 2004 in protest against this –here we can draw lessons and should not be afraid to raise our voices. They stated that nobody informed anyone that they should protest against this, but people all over the world saw this as a human rights issue and could not hold back. This energy could also be used for reviving the earth community and human ways of relating to each other.

The absence of balance in these institutions has perpetrated a crisis that extends from cells and tissues, our minds and relationships, to the health of the environment upon which life itself is dependent. It seems that there is a she–he wrangling for power that is at play silently and that neither side is prepared to talk about it. It seems as if both systems are striving for balance unilaterally in their own manner, whether of mind, body or spirit.

As the scales tip back and forth, from side to side, these imbalances in one system ultimately affect the other – and this silence about what is going on appears to be the greatest tragedy of humankind. On one side, there are the women who, as a way of proving their worthiness, resort to the assumption of masculine roles; they end up carrying a double burden while they continue to practise their vocation of healing at a subconscious level.[2] In institutions of health, they have been placed in positions of power as matrons to undermine and persecute other women for the gain of the hegemony of men.[1,8]

Walsch,[9] in his first book, *Conversations with God*, states that on earth sometimes a thought is born in one area and if it is forceful enough then it can spread to other areas. This thought of control by man can be seen in more traditional environments. In these traditional environments, in order to keep the males' needs uppermost, women themselves conduct vaginal testing and clitoris and vaginal mutilations on other women, all in the service of a specific order. At more sophisticated levels, breasts are either enlarged for the Barbie doll look or cut down to size for the small chest 'men in black appearance'. Births are hurried events, with nurses standing at the end of the bed with blades to quickly perform episiotomies or to call the obstetric surgeon to perform a caesarean section. The author of this book is of the perception that if this persists, a time will come when births will no longer occur via the vagina. When it comes to women reaching menopause, the question that is asked of women is, 'Why are you still keeping this troublesome thing (the uterus) when you are done with giving birth?' The researcher would like to hear whether men are asked why they are still keeping their scrotums when they are no longer required for any use. As female sexual organs are trivialised and cut into pieces,[1] researchers have not heard much of any male organ from the sexual area being easily dismissed and cut off into pieces. In fact, if a man has any sickness in that area, it is spoken about in whispers, in very soft and quiet voices. The sad thing is that it is no longer men who are carrying the butchering knives but other women.

In order to spare humanity, women need to let go off the role of angel or witch that they have been assigned in the past and start seeing themselves as part of the solution.[1,3,5] Like indigenous people, women must draw from their dreams and death (*the acceptance of death as life cycle*) to describe who they are.[1,2,8,9,10,11] The new cosmology can be resurrected when men and women come to full consciousness that spirit is immanent in life, as well as transcending the living. Neglecting this does not render the possibility of a continuity of life but leaves humanity with the burden of fearing death.[6,7] Mashile[12] takes this further by stating that one of the cornerstones of capitalism is the devaluation of the labour of care. Even though human beings need to be cared for to survive the different stages of life (illness, childbirth, old age and childhood), because this work is viewed as 'women's work,' it is not given monetary value equivalent to true value and worth. Our families, specifically women, are not remunerated according to the true value of their work.[13]

The need for a balanced healing environment underpinned by respect and human dignity for all knowledge holders

Nowadays, both men and women wish to express their long-suppressed female consciousness.[1] The silence of modern woman regarding this discourse has cost her and her family (according to the African perspective, every woman is a mother to every child of the village and the world). How many girls and young women are suffering from conditions such as anorexia, anxiety disorders and bulimia and are forever in the battle of trying to lose weight? The question, as Dr Phil would ask, is, 'for whom?'[13] How many of our sons have died in the army trying to prove their manhood? How many men kill, rape and maim others while they are caught in internal pain and identity crisis of who they are to their fellow beings and what role they should be playing?

It all needs to stop. Adopting only the feminine perspective could be an appealing alternative, especially in times when technology has caused so much pain and when male-dominated institutions have not rid human beings of their miseries. However, a healing system based only on the feminine perspective would be to ignore the gains achieved in the past. Rather, there is a need to harmonise the two approaches. Furthermore, there is a perception that women will be operating out of a fear of future male domination when they choose this route, and any approach based on fear can never develop a strong foundation.[1,13,14] This would be counterproductive and would lead humanity exactly to where it all started.[1,3] The female approach is not about the absolute truth; it is about a process whereby caring based on the present understanding can lead to curing. It is within this perspective that males cannot claim to be the only curers; in fact, without the female caring component, whatever curing might have been achieved cannot be successful and can even be detrimental. This has been well portrayed recently by the wife of a man with disabilities in Gibson's[15] narratives of men suffering from chronic illnesses. The wife who was the carer narrates that:[15]

> They showed him how to get the injection, he never got it right, and instead he ended up bruising himself terribly. Then they showed me how to do it. He said to see his own blood makes him feel sick. One can say his sickness became mine. (p. 177)

Aspects such as loss of hope or love and failure to adequately cope with stress have been identified as factors that can cause the onset and exacerbation of the symptoms of major illness.[1,3,5] In short, lack of caring or nurturing may be a primary cause in disease, and carers who are involved in caring are directly facilitating cure – this is the arena of women and further research needs to be conducted for it to be accorded its true value.[14] What has already been written by women healers shows that gaining equality in the Western healthcare system is no longer the main issue; rather, there is a need for women healers. Women healers now find the system itself unsatisfactory; instead of equality, they

seek massive change and the revitalisation of health institutions.[1] During this period of revitalisation, these modern sisters can draw lessons from their older sisters who are healers – the traditional older women as healers seem never to have left the mother Earth as the centre of their healing experience and practices.[5] They too are vulnerable to the present order and power as infiltration by the so-called modern life leaves none untouched, including those who live traditional lives. This has been shown in Australia where aboriginals, with the invasion by white people in their area, found women being recognised as the 'feeders and breeders' and men being groomed to be politicians by white male administrators and liaison officers. Aboriginal women have been cut out of much of the political life of the larger settlement and left in their camps to produce babies and small artefacts. Such is the value accorded to the life of women according to European reasoning. Furthermore, because it is inappropriate for Aboriginal men and women to sit together in large mixed gatherings, most consultation takes place between Aboriginal men and white males. By the time it was proposed that councils should be established in settlements, Aboriginal men had become the political spokespersons and women the followers.[15]

The role that could be played by the older women in primary healthcare

The need to recognise and integrate the IHK of the older women into the first level of PHC within a modern health dispensation must be recognised. Scott and Wenger[16] have shown that women's accounts of their health are structured around age and gender. They argue that women can become more powerful and autonomous in old age, and that despite their age, they can assume new roles and duties that are to be conducted in a caring and loving way, with expertise gained through years of understanding, knowledge and experience.[5]

Knowledge held by the older women for caring and healing

Boneham and Sixsmith[17] are of the view that the voices of the older women are rarely heard in debates about health. Consequently, there is very little research that has explored the ways in which the older women contribute to the health economy and social capital of their communities. This contribution is neither researched nor documented.[17,18]

According to Clough,[2] the talents of women have been carefully integrated into their day-to-day activities so much so that these talents have been classified and simplified as part and parcel of 'the role' woman are seen to fulfil in society, for example, terms such as labour of love are commonly and loosely used. In South Africa, with the AIDS epidemic, the older people, and specifically women, have become a pillar of strength to AIDS orphans.[19]

To value the contribution made by the older women, they firstly need to be recognised and valued as lay health experts who are regularly consulted by family and friends, and secondly, there needs to be a greater understanding and documentation of the knowledge of these women. In addition, the negative assumptions and perceptions about age, gender and ill-health in mainstream society need to be challenged. Mainstream medicine, for example, tends to label the physiological changes of menopause as being deviant, requiring intervention, and reinforces the societal assumption that the older women are weaker than men and more dependent.[17] Alternative interpretations that stress that these physiological experiences are a normal part of development need to gain currency.[17]

Boneham and Sixsmith,[17] quoting Gidham, suggest that women's dual roles as caregivers and receivers, especially those caring for people with disabilities, have been underestimated. They claim that a gendered evaluation of health and healthcare is more likely to position the older women in a more positive light

and ensure that they become active agents in health matters, especially concerning their family. The role that the older women take on in fostering a spirit of belonging, participation and identification in the local community needs to be encouraged, as well as their role in promoting empowerment and change. Data on social participation indicate that older women are more active than older men in terms of voluntary work, group membership and attendance of social events.[17] In Zonke's[20] study of the IHK carried by the older people, male participants were less vocal than their female counterparts during focus group discussions. The main qualitative contributors were the older women, even though males formed 48% of the study sample.

Bell[21] supports this concept of the empowering role of women when describing the Australian Aboriginal older women who are the active ritual leaders and the repositories of religious knowledge. They have reared children – not necessarily their own – into adulthood and have acquired the necessary knowledge befitting the status of ritual leaders. Bell[21] explains that in rituals, these women emphasise their role as nurturers of people, land and relationships. Through their *Walwuyu* (land-based ceremonies), they nurture; through their health and curing rituals, they resolve conflicts and restore social harmony; and through *Yilpinji* (the love rituals), they manage emotions. Thus, their major responsibility as ritual leaders is in the areas of love, land and health. As part of their nurturing nature, they see their role as being the custodians of 'the growing up' of people and land, as well as maintaining the harmonious relationship between people and the land. They use certain rituals to affirm their commitment and intention to 'grow up' country and kin.[21]

Bell[21] further explains that although women allow discussion of the structure of their ceremonies, they will not permit the details of songs, certain designs and ritual objects, to be made public. Occasionally, this has meant that women appear to be ritually impoverished, but they find this more acceptable than compromising their secrets. This relationship between land,

people and rituals is similar to that of women from the Northern and Western parts of the world towards their families and mother Earth before their healing practices were taken away during the systemic mascularisation and industrialisation of their livelihoods and the institutionalisation of their health vocation.[2,3]

Struthers[4] calls for an increased awareness on the part of healthcare providers who practise the ancient art of traditional, culture-specific healing and healthcare in their communities. She explains that for a long time, in the United States and Canada, it was against the law to practise traditional healing; however, despite this, indigenous healing practices continued to thrive.[22,23] The challenge now rests with how to integrate this knowledge into the highly developed biomedical care model. Previous attempts have shown that practitioners of the biomedical model are resistant to integration, claiming that indigenous healing practices are generally dangerous; instead, they prefer to influence the traditional side to change and embrace biomedicine. However, in specific countries, these attempts have unveiled what could be interpreted as positive results. For example, Hògberg[22] states that in the Netherlands, Norway and Sweden, low maternal mortality rates were reported by the early 19th century and were believed to be the result of an extensive collaboration between physicians and highly competitive, locally available midwives, especially in the rural areas. However, over time, local birth attendants were phased out as biomedically trained midwives were introduced.

Hinojosa[23] shares a similar concern regarding the approach used by Guatemalan health authorities, who consistently tried to refashion the vocational framework of Mayan midwifery in accordance with Western medical principles. The ongoing privileging of biomedical knowledge created an environment that favoured health personnel and enabled them to extend their influence through the local Mayan midwives into the community. For example, Mayan traditional birth attendants encouraged kneeling or squatting during delivery. However, these positions

were frowned upon by biomedical midwives as they argued that with these positions the child descends with too much force and the afterbirth can become stuck within the mother or be expelled onto the ground. Instead, they encouraged the lithotomic position (lying flat on back with knees raised) or a semi-reclining position. Hinojosa[23] challenges these positions by quoting Jordan, who reviewed the lithotomic position and concluded that it was dangerous because:

1. it decreases the size of the pelvic outlet
2. it negatively affects the mother's pulmonary ventilation, blood pressure and cardiac return, thereby lowering oxygenation to the foetus
3. it lends itself to the mother pushing too hard for too long and thereby becoming exhausted before accomplishing what is required, namely, the birth of the baby, which is sometimes accomplished by external measures such as forceps deliveries or episiotomies.

This study clearly shows how difficult the clash of cultures is for those caught in the crossfire of competency beliefs, values and technologies, as each approach wants to prove that it is the most effective.

Challenges facing traditional middle generation women

The younger women in rural areas face many challenges, as modern health systems distance them from the traditional, older women.[24] Not only do African women have to cope with problems of poverty and the transition from the rural to an urban environment, they also have to deal with levels of frustration, mistrust, anger and lost identities, resulting from systems such as apartheid, as they too have to deal with their husbands' and their families' levels of frustration.[25] Using childbirth as an example, Sheila Kitzinger, cited in Chalmers,[26, p. xiii] states that '[c]hildbirth is never completely natural – it is really a cultural artifact'.

In the processes and events of pregnancy and labour, we witness the shaping of nature into a social purpose. It is women who are at the centre of this cultural maze. Despite the contrasting views of traditional and Western medicine about health and illness, it might be said that women giving birth could retain the community's support for holistic, traditional birthing practices while enjoying the greater physical safety offered by Western medicine. Unfortunately, hope rarely reflects reality. More often than not, these women have lost the former, without reaping the benefits of the latter; and as Kitzinger, cited in Chalmers,[26, p. 116] concludes that 'rather than experiencing both cultures simultaneously, these women appear to be experiencing neither culture fully'.

In the traditional birthing process, information, and probably also some misinformation, was conveyed to young mothers by the older women. However, the perception of traditional birth attendants is that their methods worked. At least the preparation was congruent with women's birth experience.[26] For example, one 78-year-old traditional birth attendant is quoted as saying that she has been delivering babies in Belize since the age of 13 years and has never lost a mother. She does not use pitocin, merthergine, forceps or surgical techniques, but claims that her skills are intuitive.[24] Lately, preparations for pregnancy and birth, whether African or Western, appear not to be meeting the needs of today's women adequately.[25,26] When we compare traditional birthing practices with those practised in modern-day hospitals, it is the central concept of holism that appears most threatened. As debates rage between traditional and Western medicine about birthing techniques, it is only recently that the emotional aspects of birthing have come to the fore, and even less acknowledged are the spiritual needs of women. With a closer comparison of the two birthing settings (African birth customs in traditional and urban settings), there is a growing awareness of the gnawing fragmentation in childbirth today.[26]

Some Western-trained practitioners serving in Belize have realised that a mix of traditional and professional care yields

maximum results.[24] Bland[25] supports this notion by saying that mothers who are concerned about their infants' welfare should not be afraid to approach health professionals for fear of being chastised for what they have done or failed to do.[25,26] Instead, they should be encouraged to seek help from health professionals who empathise with their concerns and who do not criticise them, who give clear and consistent explanations regarding their infants and who provide reassurance about perceived difficulties that do not require medical help.[26]

Clinical nurse practitioners and primary healthcare in South Africa

The role of the CNPs in South Africa is to take the patient's history and to do a basic screening regarding whether the patient should be seen by themselves or a doctor, and to manage minor health problems.[27,28] Since 1970, because of the shortage of doctors at the primary level of healthcare in South Africa, more and more medical responsibility has been shifted from the doctor to the CNPs. Mash[28] explains that South Africa has been unable to train doctors who are suitable for South African rural health needs, and also has not been able to carry the economic burden of overskilled and inappropriately trained doctors to provide basic care. It appears that there is also unwillingness on the part of many doctors to work in the areas of most need.[28] Hence, the idea was that the CNPs should alleviate the doctor's workload by seeing a reasonable number of patients and by attending to minor ailments, leaving doctors to attend to more complicated cases. The CNP was to utilise his or her nursing skills to educate patients presenting with chronic illnesses.[20,27,28]

According to Mlenzana and Mji's[27] study, these CNPs are the older women and can be compared to the Australian Aboriginal women who practise their traditional dances and dreaming for healing.[21] They can also be compared to the people of Belize who quote Miss H's methods of assisting women to give birth, in which the CNPs act as mini-doctors at the primary level of care.[24]

There might also be CNPs who are mothers and grandmothers in their own homes. Mlenzana and Mji's[27] study reveals how, during interaction, the predominantly women patients are reluctant to expose the care that they give in their homes, as they fear being chastised in CHCs by the CNPs who are also mainly women, and who are usually their first point of contact in these CHCs.

Mash[28] maintains that the role of the CNP will continue to increase and come into sharper focus in a 'nurse-driven' district health system, as the South African government attempts to implement its PHC policies. They could well come to be perceived as 'mini-doctors'. However, many questions remain, such as, 'what skills will be sharpened, as CNPs are schooled to become mini-doctors?', 'will these be skills that continue to distance them from other women?' and 'will these women allow themselves to be used as instruments to continuously sharpen the isolation of traditional women healers *at this primary level of healthcare* and assist in the development of new, primarily male-dominated, institutions at this level?' Kanter[29] explains how outsiders (newcomers or people who are not part of the situation) behave when they see themselves as 'tokens', and how they role-play and mirror-image those whom they believe to hold the power that could make them one of the 'desirables' (insiders) in the organisation.

Mashile[12] comments on women's capability to juggle several tasks, but she also challenges this notion. According to her, this skill is practised to its fullest when women are supported. Clough[2] maintains that pregnancy, giving birth, raising children, nurturing and caring, as well as reflection are all part of being a woman and part of healing. The medical model has erased, and repressed, these features from the biomedically trained CNP.[20] Kanter[29] remarks about the tendency of women to behave exactly like their male counterparts when integrated in institutions that were initially dominated by men as they too were actualised to repress their own feeling and exonerates the feelings of men to be accepted even as growing up girls. To gain acceptance from these institutions, they regress and behave as young girls who when growing up have to gain the acceptance of their fathers by

unquestioningly following in their footsteps.[29] Through dialogue and discussion, these features can be emancipated and again brought out into a conscious awareness level, with women re-establishing their rightful role of caring even within these male-dominated institutions, thereby laying the ground for the concept of caring to be further studied and researched with regard to its tenants.

The link between indigenous health knowledge and this study

In 2005, Mlenzana and Mji[27] commented on the complex relationship between health professionals and their personnel. They highlighted the multiple dimensions of health mentioned by Fry,[30] Denhill et al.[31] and Niven[32] and pointed out that the way we lead our lives will directly and indirectly affect our health. The community health forums that discussed the problem of overcrowding at CHCs in Khayelitsha also recognised the complexity of health-seeking behaviours, which they understood in the context of rural–urban migration, broken family units and lost traditions. They also drew attention to the scarcity of community-based resources, such as the IHK carried by the older people. Their interpretation of health-seeking behaviour does not fall far from that of the indigenous peoples worldwide.[33,35]

Traditional knowledge is an important part of South Africa's cultural heritage. Before the development of synthetic chemicals, plants were an important source for the ingredients of medicines. They were also used as a source of food and as material for equipment. Wherever European cultures colonised the world, this indigenous knowledge went underground and was practised in secret.[34] However, South Africa cannot afford to embrace an exclusively Eurocentric medical approach. This notion is supported by Bührmann[34] who asserted that the concept of 'community involvement' implies that healthcare is not only the responsibility of external agencies and specially trained health practitioners or the family physician, but that the whole

community has a responsibility to ensure that the health of every member is maintained at an optimum level. She argues that health in many preliterate societies, and even the survival of the group as a whole, would depend on the ability of all individuals to fulfil their roles, as well as the knowledge of healing that was transferred across generations. The challenge facing us today is to make the descendants and the owners of this huge reservoir of traditional health knowledge and medicines once again proud of their knowledge and confident enough to share it.[33]

In Mlenzana and Mji's[27] study, only 6% of the older people who visited the CHCs presented with MHAs. They postulated that the reason for this low percentage might be that some the older people living in Khayelitsha and Phillipi are still using their IHK. Zonke[20] supports this view but raises concerns regarding the retention of this knowledge, which will be lost as the older people die without having documented or passed on their knowledge. In recent years, traditional healers have been recognised and are collaborating with medical practitioners in managing and delivering PHC.[36] However, there is no mention of the role of the older women in the care of health problems in the home.

This study has posed, *inter alia*, the following questions: Within a PHC framework, how could the older women play a more prominent role as first-line practitioners in the home? Could they be afforded the vital role of preserving the plants used for healing purposes, just as the women in the Indian healthcare system have the role of ensuring the survival of the healing Tulasi plant in their homes (as they ensure the survival of their own children)?[36] How can the survival of IHK be prioritised for coming generations?[36] What this study ultimately asked was, 'what indigenous health practices happen in South African rural communities?'

Indigenous health knowledge systems in Southern Africa

This section covers IHK systems in Southern Africa. It provides an overview of Southern African indigenous health management

strategies, with the main focus being on the management of psychiatric illnesses. Different perspectives are presented about the world perspective underpinning IHK. The section concludes by highlighting the need for further research into IHK.

Unlike the literature already presented,[35,36] the literature that has explored the perceptions of the people of Southern Africa regarding their health and wellness is minimal, with most of the available literature focussing on the actual illnesses of individuals.[10,34] This might be related to the patient–clinical health professional interaction that occurs. Professionals tend to be both researchers and writers and tend to be based in those medical institutions where sick individuals come to consult for their illnesses. Abrahams et al.[5] are of the opinion that in Southern Africa, studies into IHK revolve around the harm it does to patients. This means that there is minimal literature that portrays IHK as contributing to the evolving knowledge of health, which also requires research for improving it.[35,37] The literature review concentrates on perceptions of illness of people residing in the southern part of Africa, with a specific focus on the Xhosa tribe.

In the Eastern Cape Province of South Africa, where the early European settlers and missionaries first encountered Xhosa diviners and their traditional healing practices, these practices were considered as the mainstay of the grossest darkness of humankind.[35] In the 19th and early 20th centuries, Western healthcare, in the form of tropical medicine, focussed mainly on major epidemic diseases such as variola, cholera and plague, as these flourished in the tropics where there was very poor hygiene. The development of bacteriology and serology yielded prophylactic means to prevent these dangerous diseases.[38] Nowadays, most of these quarantine diseases are a thing of the past.

In the second stage of Western healthcare, the focus turned towards chronic endemic diseases, such as yaws, leprosy, malaria, venereal infections and filariasis. Prevention of this group of diseases was often approached by way of mass campaigns so much so that in the case of malaria, the mosquito became more

important than the patient. This second stage was characterised by poor communication. Jansen[38] cites the missionary doctor, Cicely Williams (1958), who remarked that, '[t]he basis of these campaigns is usually to devise measures that demand population acceptance rather than active cooperation'; and with a touch of humour she added to this:

> Let us pray for your house that this will prevent malaria, let us give an injection, this will cure your syphilis and your yaws, let us inoculate you, this will protect you from tuberculosis. (p. 2)

The greatest challenge faced by missionaries, who were both medical personnel and educators, was how to overcome the resistance to the introduction of Western medicine amongst the indigenous Xhosa population. The Western doctor would typically brush off his indigenous patients and did not pay sufficient personal attention to them. Being overworked and overburdened did not help the situation either. This lack of attention, according to Jansen,[38] is what caused the indigenous patient not to trust Western medicine. Jansen[39] expands on this idea by saying that the problem in Western medicine is that investigations concentrated upon certain mechanisms, special organs and systems. The patient was provisionally ignored: They were merely the incidental battlefield of bacteriological conflict, or an irrelevant container of a fascinating biochemical process.

This perception is further expanded upon by Bührmann[34]:

> We are getting too one-sided in our development of the rational side of our being and thus getting psychologically impoverished and also severed from roots which nourish us. How can we claim to be healers when we have become technologists? Especially healers of people to whom technology has less meaning and the human being is still supreme? This might be partly because Western technology is moving away from the essence of being human and from participating creatively with the rest of the world. The Xhosa healer is not only essential for his own people, but to some extent for all of us. (p. 18)

Bührmann[34] was not far off the mark – indigenous people saw biomedicine and the modern world as having made a big mistake by ignoring the IHK systems.[35]

Southern African indigenous health knowledge management strategies

Berg[39] estimates that up to 80% of South Africans consult traditional healers. The University of Cape Town has attempted to bridge the gap between the traditional and the Western biomedical approaches through the publication of the *South African Primary Health Care Handbook*. The focus of this book is on physical diseases and their treatment. Berg[39] explains that if it is true that traditional healers seem to work most successfully with psychological and psychosomatic illnesses, then it is imperative for psychiatrists and mental health professionals to understand the psychological mechanisms through which healing takes place.

Recent South African research on mental health, from a postmodern political perspective, shows that the stereotyping of African culture was part of an abusive system, with disastrous effects on the healthcare system in South Africa. Berg[39] argues that ancestor reverence, as mentioned in Maelene[19] and Liddell et al.,[40] has a deeper meaning and embodies Xhosa traditional healing methods; however, this core concept is often mentioned only fleetingly by researchers in the mental health field, such as Swartz.[41] Berg[39] mentions two exceptions, namely, the work conducted by Madu, Baguma and Pritz, in the World Council for Psychotherapy – an African Chapter – and the pioneering work of Vera Bührmann in the 1970s and 1980s.

At that time, Bührmann was the only Jungian analyst in the country, and Berg[39] maintains that her work is becoming more relevant in the current South Africa where there is a sense of urgency for the African worldview to be respected. Bührmann, cited in Berg,[39] echoes the insights of Maelene[19] and Liddell et al.,[40] who warned that failure to respect the African worldview will have disastrous consequences. Berg[39] maintains that we need to understand issues related to ancestor reverence and IHK in general, as well as approaches to psychosocial illnesses, in particular.

Traditionally, Southern African IHK management strategies involved ancestor reverence, particularly in healing psychosocial illnesses. People consulted traditional healers who were highly trained therapists and who used the physical structure of specific traditional rituals in the healing process, for example, drumming and dancing. There was family and community involvement, and last but not least, dreams were key to the process of healing.

Ancestor reverence

Ancestor reverence is a way of understanding the world; it is not a religious system. Christianity and ancestor reverence can and do co-exist, where *ancestors are revered* and *God is worshipped*. This important fundamental distinction escaped the missionaries of the past who talked about 'ancestor worship' as 'lapses into heathenism'. It is this European prejudice lodged in the subconscious of the Western psyche that could account for the reluctance of the Westerners to look at the practice of ancestor reverence from a positive, constructive point of view.

The notion of ancestor reverence pertains to the general belief that something of the dead person does not wholly disappear, that something survives and is given substance by respecting those who have died. As already mentioned when discussing IHK, humanity, in the context of African thought, includes not only the living but also the dead who play an important role in the whole universe of forces and continue to interact causally with the living. The ancestors are the 'living' members of the family and clan who have died, but who continue to live on as 'shades'. There is a live, human, relationship between the individual and his or her ancestors – the ancestors act as guides and mentors. *Their presence is the main factor in maintaining good health.* They are omnipresent and their influence is benign and all-embracing. There is a symbiotic relationship between the ancestors and the living – with the living keeping the deceased in mind and honouring them through ceremonies, and in return receiving their protection.[35]

Highly trained traditional healer therapists

A majority of traditional healers are highly trained therapists. The English term 'witchdoctor' is an unfortunate one. It belongs to the genre of colonial literature, evoking exotic images of cunning darkness. Berg[39] maintains that Hammond-Tooke[42] rightly argued that it is perhaps necessary to place an embargo on the use of this term. The extensive training that traditional healers undergo has been described by Bührmann.[43] Over a period of several years, candidates are initiated in a process that requires rigorous preparation and ancestral approval. Healers should thus be regarded as the equivalent of skilled psychotherapists. Berg[39] further explains that African philosophy and thinking is rooted in two fundamental concepts: *Ubuntu* and ancestor reverence, with the former being a binding African concept.

Ancestor reverence and psychosocial illnesses

The application of ancestor reverence to psychosocial illnesses is prevalent in indigenous healing strategies. The individual is linked through his or her clan to his or her ancestors. Rituals are performed at important points in the person's life cycle or at any other time as necessary. Through these rituals, the communion, that is, the link with ancestors, is re-established. The ancestors are heeded and respected through rituals and, in turn, they act as protectors, mentors and guides for the individual. Should they not be attended to, they withdraw their protection. It is in this lack of connection (broken link) that the individual becomes exposed to the powers that have an opposing effect on one's health. In psychoanalytic language, it could be said that by paying attention to the subconscious, the individual's ego functioning is strengthened. If the subconscious is ignored, the ego becomes brittle and may decompensate and succumb to negative forces within the psyche. If things go well for the individual, the ancestors may remain in the background of consciousness, but if not, they

manifest themselves through dreams and bodily sensations, or even illness.[43] A ritual may then have to take place in order to re-establish the connection between the individual and his or her ancestors.

The use of rituals in promoting health and preventing illness

Berg,[39] quoting Hammond-Tooke, suggests that rituals are the techniques that humankind has devised in order to manage satisfactorily their relations with gods, nature and their fellow beings. In African tradition, there are no set collective times for rituals as in the liturgical calendar year of religious systems. The occurrence of rituals is individually determined, and three types of occasions are noted:

1. the life cycle rituals of birth, initiation, marriage and death
2. rituals to thank the ancestors for the successful accomplishment of a task
3. rituals when illness strikes.

Berg[39] describes four aspects (*intlombe*, drumming and dancing, dreams and reverence of ancestors) that form part of most ritual happenings and that serve to illustrate how these facilitate the important psychic function of making links with the ancestors.

Intlombe – The physical structure of the ritual

Berg[39] explains *intlombe* as a Xhosa dance that is performed as a ritual indoors. There is a basic four-ringed structure, formed by the walls of the hut or the house, the circle formed by the family and community, the circle formed by the dancers and the centre place, which is the hearth, the place of warmth and food.

This basic structure forms the framework within which different types of ceremonies are performed. Bührmann[44] observed that

this structure is that of the universal mandala, with two non-human and two human circles as the basis. The word 'mandala' means 'circle' in Sanskrit. Mandalas are usually made up of several concentric circles that are there to 'shut the outside and hold the inside together'.[45, p. 630]

The healing occurs through two fundamental, early psychic processes: Establishing links and containment. Berg[39] states that these have been formulated in the language of objective relations. Bion[46] describes the containment, which the mother provides for her infant, and how within that containment the link between inner objects is enabled. In the language of analytical psychology, it could be said that the mandala structure provides the template, within which the union of the opposites can take place.[44]

When there is psychic turmoil, the individual above all needs containment. It is well-known in analysis that dreams with mandala images appear at a time when there is upheaval in the dreamer's inner or outer life. Jung[45] showed in numerous case studies how mandala images appear in spontaneous drawings of patients of various ages and noted the ordering and containing effects of these presentations. In traditional African culture, this containment is externalised and reinforced through the structure of the ceremony. This offers an emotional holding in which the outside is shut out and the focus is on the inside.

Family and community involvement

Consultation with a healer is never done alone. The patient is always accompanied by at least one significant other. Rituals are always performed with members of the affected individual's family and people from the community. The *intlombe* can be regarded as a special form of group therapy. Berg,[39] quoting Nqweni,[47] compares the African *intlombe* with Western group therapy processes.

What distinguishes the African group from the Western group therapy is that in the former there is a relationship between the

group members – usually family members, actively involved in the life of the person for whom the ritual is being performed. This is a manifestation of a unified concept of the individual in which one is not isolated but becomes part of others, while in Western culture the developmental goal is to separate the individual from the family, thereby making him or her an isolated individual.

The function of the healer is also different from that of the Western group therapist. The healer conducts the *intlombe* in a directive manner and has a mandate, and indeed is required to give directives. The mandate enables the healer to give direct advice to the group members. This is because the healer functions as a mouthpiece for the ancestors whose authority is vested in him or her. The communication thus takes place not only on a conscious or personal relation level but also on a primordial, archetypal level. The linking that occurs is between the individual and the community, and between the individual and the ancestors. This is further enhanced by the active participation of the body in the group process.[44]

Drumming and dancing

Amongst Xhosa speakers, no ritual occurs without the participants drumming and dancing. The dance is called *xhentsa* and consists of a special rhythm and stamping beat, with the bare feet of dancers pounding the earth in a slow, regular and firm manner. Dancing occurs in a group setting with others moving in an anti-clockwise direction around the central fireplace, and it is an activity that focusses on the internal world of the dancer.[48] The participants are preoccupied with themselves in an intense manner – *they think and sing about their illness*, talking about it and about their ancestors.[48]

A further function of the *xhentsa* is the activation of the body through vigorous movements. According to Damasio,[49] it is well-known that endogenous opioids are produced with exercise, which in turn have a direct effect on the individual's sense of well-being.

The rhythmical aspect of drumming and dancing requires more in-depth thinking. Berg[39] mentions Damasio[49] and Maillo[50] who examined the rhythmical dimension of the mother–infant relationship, and makes the point that rhythm forms part of the human being's procedural knowledge and memory, and is part of primary development. She writes about the function of a regular rhythm as being the constancy and reliability (which) may be indispensable ingredients for the establishment of basic trust. The ritual tends to give a containing effect through a physical structure and is thus further enhanced by the auditory and bodily component of the rhythmical beat.

Dreams

Berg[39] explains that dreams move one from the physical container, the group and the body, and attention is turned to the innermost process, namely, that of the dream. No meaningful, in-depth psychotherapy in Western culture occurs without having tried to give an interpretation of dreams. However, dreams generally do not form part of everyday, shared, ordinary life.

In the African worldview, dreams are very much part of everyday life and not dreaming may become a serious problem and could be a reason for performing a ritual. 'The dream is to see the truth at night [...] the dreams are the truth because ancestors never deceive their children'.[49] Dreams are regarded as messages from ancestors. They have both therapeutic and prognostic value. Although the actual symbolism contained in the dream is usually not analysed in the way it would be in Western psychotherapy, the dream is fully experienced and its message is acted upon. The 'royal road to the unconscious' is here travelled with a seriousness that is often missing in European culture. The role of traditional rituals is to help the person dream, to share the dream and to find the meaning in the dream. For this, the healer's knowledge and skills are needed and he or she is the link to the ancestors.

To sum up, Berg[39] states that traditional rituals have a positive effect on mental illness because they address the fundamental human need of establishing links. In the African worldview, disconnectedness can cause profound suffering as well as ill-health. Through rituals, connectedness is re-established, and links are made between the individual, the family and the community, and between the body and mind. All of this occurs within a ritual space that is presided over by the healer who has been trained and acts on behalf of the ancestors.

Psychological position of ancestors

Berg[39] concludes that dreams are fantasies about images of ancestors and are projections from the collective layers of the unconscious. This deep layer of the unconscious is the realm of the archetypes that connect us all as human beings. This idea was initiated by Freud[51] who intuited its existence when he wrote about the primal fantasies as our phylogenetic endowment. Jung[45] expanded on this work. The collective unconscious is part of the psyche, which can be negatively distinguished from the personal unconscious by the fact that it does not, like the latter, owe its existence to personal experience and consequently is not a personal acquisition. The collective unconscious is made up of archetypes that are unconscious images of instincts, and hence universal to all humankind. The human endeavour is to integrate unconscious forces into the ego, the centre of consciousness. The realisation that the ego is only a small part of a whole is in line with Freud's revolutionary discovery of the power of the unconscious. Recognition of the collective unconscious takes this one step further.

The archetype of wholeness – what Jung termed the 'self'[45] – occupies the centre of the collective unconscious. It is a symbol of unity and wholeness, which in traditional religions is understood as the concept of God, the imago. Jung[45] posits the notion of a hierarchy of archetypes, with the self being in the highest position,

but requiring the realisation and help of the lower archetypes in order to obtain this shadow, animus, or wise old woman. If some of these were translated into Judeo-Christian concepts, we would call them angels, or the messengers of God, with the self-possessing numinous qualities, that is, extraordinary, compelling supernatural powers. Berg[39] hypothesises that the ancestors occupy a midway position between the ego and the self. Ancestor reverence is often misunderstood as threatening traditional religions and is misperceived as religion, per se. This misunderstanding is based on the erroneous judgement of the ancestors as 'God'.

Berg[39] concludes that much harm has been done by those local churches in South Africa that forbid the ritual honouring of ancestors on the grounds that these are 'pagan' rituals. This has led to a separation from the roots of a very old, profoundly meaningful healing cosmology. The traditional ceremonies that were discussed earlier are a manifestation of the human need to find a way in which to honour the unconscious and to find meaning. In a traditional African culture, this is done through the belief system that reveres the ancestors, who in turn act as intermediaries to the higher being. The notion of a collective unconscious and the concept of the archetypes form the basis of culture, health and illnesses. According to Berg,[39] the only real understanding of the health-seeking behaviour of patients is a psychological interpretation that explains the deep desire of individuals to have a genuine respect for each other, despite cultural differences.

The need to research indigenous health knowledge

In the past, the limited research that was conducted on IHK focussed on quantitative rather than qualitative studies and was driven by pharmaceutical companies in partnership with schools of medicine that focussed on trials of efficacy.[52] Very few studies

focussed on accessing and assessing the quality of indigenous healthcare.

It is against this backdrop that it is important to understand the prevailing perceptions about research on IHK in general,[34,54] and IHK carried by the older women in particular.[20] In the past, the war waged against indigenous people raged around territorial lands, waterways and oceans.[34] Increasingly, these contests have shifted to the intellectual realm, to cultural practices and to the terms under which indigenous knowledge systems can survive in modern times for the benefit of indigenous knowledge, which will ultimately benefit all peoples, as indigenous knowledge encourages the protection of nature and the earth that supplies us with the means to produce food as well as medication.[7,8,32,34] The health-seeking behaviours of indigenous people, coupled with the need to deliver comprehensive healthcare, have been a drawing force for researchers who see this terrain as an important area for exploration.[19,34,36,41]

Science and indigenous knowledge

Three debates have taken on distinct forms as a result of the modus operandi between science and indigenous knowledge, namely, opposition to the promotion of science as the only valid body of knowledge, the rejection of science in favour of indigenous knowledge and the misinterpretation of knowledge by the use of system-bound criteria.

Firstly, opposition to the promotion of science as the only valid body of knowledge has attracted many followers. In the past few centuries, progress in science in the Western world has become the dominant global knowledge system and has often been accused of being narrow in focus and intolerant of other persuasions. If a conclusion cannot be supported by concrete empirical evidence, if a practice is not evidence-based or if there is an inability to replicate results, then validity is in doubt.[34] Method is important and objective measurement is even more

important and becomes the final arbiter. Systems of knowledge that do not subscribe to scientific methodology are afforded a lesser status and, if given any recognition at all, run the risk of being explained according to scientific principles.[19,34,36,41] If it is not totally discounted as irrelevant, knowledge that may be called 'non-scientific' and use scientific methods to try and explain it to the extent that it is rendered meaningless because it is out of context with other components of scientific explanation.[36]

At the other extreme, the second debate revolves around the total rejection of science in favour of indigenous knowledge. Just as science has either ignored indigenous knowledge or re-interpreted it to fit in with scientific logic, indigenous people have in turn frequently dismissed science as an illegitimate knowledge base because it seems incapable of explaining spiritual phenomena or even recognising the existence of nature as something more than a scientifically observable construct. Sometimes, the rejection is simply based on the fact that science is associated with, and seen as 'a tool' of, the coloniser. A more complex argument is that standard scientific method is based on analysis into smaller and smaller components, while indigenous knowledge places greater emphasis on the construction of models where multiple strands can be accommodated to make up an interacting whole. Understanding comes not so much from an appreciation of component parts, as from the synthesis into a complex whole – thus the underlying bases of both systems are in conflict.[34,36,41]

Finally, misinterpretation of knowledge by the use of system-bound criteria occurs. Indigenous mistrust of science, on the one hand, and scientific disregard for indigenous knowledge, on the other hand, have a common tendency to evaluate each other based on their own system-bound and limited criteria. Science is one body of knowledge, faith is another and indigenous knowledge is yet another. The tools of one cannot be used to analyse and understand the foundations of the other, or to draw conclusions about the different systems of knowledge.[34,36]

Exploring the interface

The relative validity of science or indigenous knowledge is usually contested on the basis that one is inherently more relevant than the other. Hardly ever does such a polarised debate generate wisdom and seldom does it lead to the generation of new knowledge or fresh insights. Instead, positions become more entrenched as proponents defend their ideological positions.[36,41,46]

The literature review has shown how individuals seeking healthcare often achieve their own form of holistic healthcare using both Western and indigenous healthcare. It is not unusual for scientists or indigenous peoples to live comfortably side-by-side with the contradictions of different bodies of knowledge. Many scientists subscribe to religious or spiritual beliefs. Likewise, many indigenous people use scientific principles and methods in everyday life while at the same time holding onto their indigenous values.[35] Many traditional healers have adopted some Western methods to enhance their practices,[48] while some Western doctors recognise and acknowledge the healing qualities of IHK. Rather than contesting validities, each uses the interface between science and IHK as a source of inventiveness. They have access to both systems and use the insights and methods of one to enhance the other.[54] The focus shifts from proving the superiority of one system over another to identifying opportunities for combining both.[37]

Whittaker[55] has argued for a social contract and a broad agreement about training, which will produce health workers in all sectors of the healthcare field and educate them on the need to work collectively for the common good of all.

Researching the indigenous health knowledge carried by the older Xhosa women

There is an urgent need to research the IHK carried by the older Xhosa women in particular because it is believed that this

knowledge lies at the interface between the healthcare system and the home.[20,27] There are many reasons for the need to explore this knowledge. Firstly, most of the older women who are the carriers of this knowledge do not have formal education. Hence, measures of documentation using other methodologies need to be put in place to ensure that their indigenous knowledge is preserved for future generations.[36]

Secondly, in the past, IHK survived through word of mouth by teaching it to the next generation who continued as the carriers of this knowledge. Nowadays, with the migration of younger people to cities, this chain of information has been broken and the death of an older person means the loss of a rich reservoir of IHK[20,27]

Thirdly, the researcher is of the view that there is a dire need for a model, based on IHK, to assist with the containment of MHAs within the home situation. However, before such a model can be implemented, studies are needed to explore the following:

1. What is the pharmacological reaction of some of the herbs used by the older women to contain MHAs within the home situation?
2. If dangerous substances or medicines are being used, these will need to be discouraged. In this context, knowledge, attitudes, beliefs and practices (KABP) studies will need to be conducted regarding the use or disuse of these medications.
3. As there are at least 11 languages in South Africa, it is assumed that the above studies would apply to indigenous health practices beyond the scope of the older Xhosa women. Hence, there is a need to explore the IHK across South Africa's diverse cultures.

Finally, there are five community-based concepts or principles that could be used to make PHC more effective, namely, the concept of *Ubuntu*,[56] social capital,[57] the asset model,[58,59,60,61] horizontal learning, community participation and developing meaningful relationships with communities (the backward and

forward concept was mentioned by the key informant from Madwaleni, Chieftain Tinky-Penny, cited in Mji.[62]). All these concepts or principles are readily available in communities and could easily replace neoliberal terms such as 'development' and 'empowerment' that external agents use as their advocation tool. Such neoliberal terms are a matter of concern to the key informants of Madwaleni who see such approaches as having undermined their beingness and becoming. There is a need to first research the earlier mentioned concepts or principles in the context of how they are practised in communities and then, once understood, use methodologies such as participatory action research to integrate their core principles into PHC programmes and into the curricula of the Faculties of Health Sciences in South African universities. It is within this approach that the perception held by the Chief of Madwaleni that biomedicine, religion and education have lowered the health indicators of their quiet existence could be laid to rest, and new reconciliatory models of health practice, which respect the human dignity of all, are held as the uppermost principle.

Concluding statement

This chapter emphasises that health is a resevoir for life. It further gives a brief synopysis of a historical space of building health institutions that were mainly led by men. It advocates for a balancing effect with all knowledges respected by everyone. The chapter further draws attention to the development of health systems in Southern Africa and the challenges faced by missionaries, missionary doctors and missionary educators to achieve compliance with Western medicine amongst the Xhosa population. It expanded on the lack of understanding of indigenous knowledge and Xhosa culture by Western medicine. As the missionaries were orthodox Christians, it was difficult for them to accept the link between health, ancestors and the dead. Berg's[39] study outlined Xhosa psychiatric management strategies and the use of rituals to demonstrate the integration of ancestors

within the psychological make-up of the Xhosa individual. Berg's[39] outline of indigenous psychological approaches and how they equate to modern approaches illustrated the value of the approach used by indigenous healers for mental health or illness, and could be a starting point for the integre research. It is important that the tools of one are not used to analyse and understand the foundations of the other, or to draw conclusions that cannot withstand scientific scrutiny, and vice versa.

Chapter 4

Research methodology that drove the study

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Introduction

This chapter addresses aspects that need to be considered when conducting indigenous research. It further describes the main features and the nature of the research design that informed and drove the study. The research site and the process of community entry and of developing community partnerships are outlined, and the affirmation of the methodology of the study is described. The study population, sampling strategies and the methodology are presented. The data collection process and the measures that were put in place for data capturing, storage and analysis are described. The steps that were taken to achieve rigour and trustworthiness of the collected data and of the study are given. The chapter ends with a conclusion statement.

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Aspects to consider in conducting indigenous research

This book posits that all people are born as researchers; if that were not the case, humanity would have ceased to exist.[1] The chapter further acknowledges that indigenous scholars and their methodologies have been excluded from being part of the voices that create and shape the world and even when these knowledges are included, no acknowledgement is given to the indigenous scholars that have contributed to these knowledges. The argument is not about who produces research, but about which research gets formalised and its methodologies mainstreamed into formal education. During this early stage of decolonising indigenous research and its methodologies, this book intends to start opening some spaces for indigenous research methodologies to come to the fore; it is within this context that this chapter on methodology will ensure the following:

1. *It uses an indigenous lens of the participants as a guiding tool*: In the early stages of community entry, the researcher understood from the chief of the area that the *AmaBomvana* saw themselves in the earlier days as proud civilised warriors whereby certain cultural obligations had to be observed before one earns the status of being *Bomvana*. The chief further explained that in his perception, the health indicators of the area were very low, and to him it all started with foreign missionaries who entered their quiet existence carrying health, religion and education, undermining the fact that all three factors were already in existence in their area. This assisted the researcher in starting to develop an understanding of the *Bomvana* people and to see whether the research findings would affirm the chief's perception about the *AmaBomvana*. This approach is similar to Durie's[2] experience while doing research amongst the Maori, where he gained an understanding of who the Maori tribe were and that to them, wellness means more than the removal of symptoms. Health was seen as a cultural identity and part of the 'self'. Being a healthy person within the Maori tribe was seen as being a Maori. Health was

measured according to participation in tribal activities and inclusion in family celebrations.

2. *Definition of health*: Similar to the Maoris, the *AmaBomvana* saw certain obligations that were to be met to be *Bomvana*, and all these obligations pointed to the health of the home. From the above historical understanding, including how the Maori, who appear to have attributes similar to the *AmaBomvana*, see health, the researcher could observe how the participants related to the health of the home and how this links to earlier concerns of this book with regard to the implementation of PHC and its overlooking of social determinants of health, such as the health of the home.[2]
3. *Cultural sensitivity*: The researcher was aware of the need to be culturally sensitive during the research process and tried to conduct research in the natural environment of the participants – which for the older Xhosa women was their homes. She also ascertained, during the early stages of community entry, that the culture of *ukuhlonipha* [respect] is used as a tool designed to maintain community peace and cohesiveness, and during the early stages of her research her aim was to observe and not to criticise as she could see that the *AmaBomvana* had a patriachal society and the culture of *ukuhlonipha* was leaning more towards serving the needs of the males of the area. This also relates to *language issues in that* interviews were conducted in Xhosa, the mother tongue of the older Xhosa women. The researcher speaks this language fluently and comes from a similar cultural background as the participants.[3]
4. *Terminology used*: Mishra, Hess and Luce,[4] in their paper on predictors of indigenous healing used amongst Samoans, emphasised the use of the correct terminology when conducting IHK studies. In their study, they opted to use the term 'indigenous' in contrast to terms such as 'native' or 'traditional', as these two terms were seen as fixed and not evolving, as IHK does. For this research, the term 'indigenous health' was used for the healing practices of the older Xhosa women in their home situation. An attempt was made to avoid terms such as 'traditional healing' or ' traditional healers'.

5. *Distance from health centre*: Vandebroek et al.[5] measured how distance from health facilities influenced the use of IHK. The study showed that increased distance from the health facility was directly proportional to the increased usage of IHK plants. It was ensured in the selection of participants of the study that some were closer to the health facility and others were further away. The researcher has described how these distances influenced the practices of the older Xhosa women with regard to their retaining the use of herbs and the IHK.
6. *Prior knowledge that the researcher brings to the study*: Lastly, the researcher reflected on her lived experience of having interacted with and been under the mentorship of five women in her early development, and how she perceived that these experiences impacted her development and actualisation, at the personal and academic level, and along her journey of exploring this topic. Consequently, these women have also had an indirect influence on how the thesis developed.[6] The rationale for this exercise was an attempt to delineate part of the subjective stance that could undermine the rigour of the thesis and to use those elements that could strengthen and bring value to the study.[7] Three themes were identified from the narration of the encounters with these women (1) transfer of attributes and skills related to growth and development; (2) transfer of values and principles; and (3) knowledge and skills that the researcher perceived that the older women had.

Aligning research design with qualitative research methods

The research design for the study was built around four distinct features:

1. qualitative and reflective
2. descriptive, exploratory and retrospective
3. ethnographic
4. feminist and emancipatory.

The main features of these study designs are presented below:

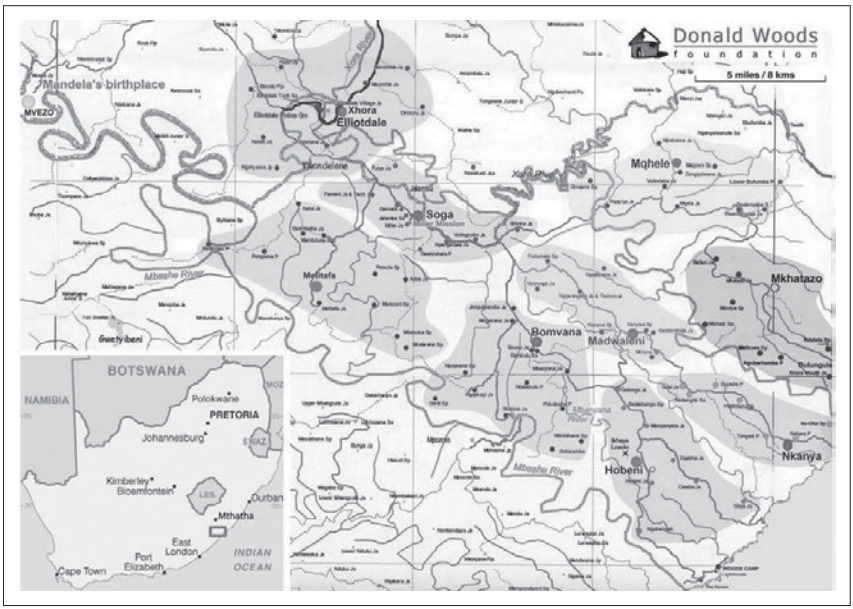
1. ***Qualitative and reflective***: The main driving methodolology underpinning the research of this book are qualitative methods, which included a reflective process at every stage of the study. It is this reflective process that guided the researcher to recognise the importance of the interconnectedness and interaction of the study's different design components.
2. ***Descriptive, exploratory and retrospective***: These are essential when breaking new ground because they afford space for reflection about events and facilitate the probability of yielding new insights and an understanding of the area in the research process.[7] In this study, the IHK carried by the older Xhosa women in their care of health problems within the home situation is described, and most importantly an attempt is made to present the interpretation of these practices through the eyes of the older Xhosa women. There are two major challenges with descriptive retrospective studies. The first challenge is related to the people who are being investigated – that they should be well represented.[7] The second challenge is related to the retrospective nature of the design, whereby time lapses could cause vital elements of the information to be forgotten or presented in such a manner that it compromises the validity of information.[8] This study has taken this into consideration by using Zonke's[9] study outcomes that demonstrated the availability of IHK in Khayelitsha and the need to further explore this knowledge in their place of origin, that is, the Eastern Cape province.
3. ***Ethnographic:*** Through the eyes of the older Xhosa women, the participant culture was understood from the viewpoint of the people who inhabit and inherit that culture. By giving voice to their prior knowledge of healing, narratives of life stories and personal experiences by the elite older Xhosa women regarding wellness and illnesses, and how health problems were managed within their home situation, were encountered; life histories were relived through questioning and extrapolation of who the older Xhosa women were and, in

particular, who were the elite older Xhosa women, and how did they engage in inquiry and used various management strategies to deal with health problems.

4. ***Feminist and emancipatory*:** Feminist and emancipatory research designs are reflective in nature and share a common theory about power and domination. Emancipation research speaks about the theory of minority groups and the process of giving voice to their cause.[10,11] The older Xhosa woman carries a triple burden. Firstly, her healing knowledge is classified as 'merely' part of her role as a woman (and as such is not validated in the same way as a male or female whose skills and knowledge are certified outside the home)[9]. Secondly, her knowledge is classified by the Western culture and paradigm – which sees itself as the arbiter of modern, progressive knowledge – as being part of the group of minority knowledges that have been ignored by allopathic medicine.[9] Lastly, because the older Xhosa woman passes on her knowledge by word of mouth, she faces the challenge of not having a voice to carry this knowledge into the global arena. This is mainly because her knowledge is caught in an environment that lacks access to the global arena because of factors such as illiteracy and technological deprivation.[12]

Study setting

The 18 villages of Gusi in Madwaleni, where the study was undertaken, are in the district of Elliotdale in the Eastern Cape Province of South Africa. Elliotdale lies between Umtata and East London, and between the Umtata and Bashee rivers (see Figure 4.1). The 18 villages of Gusi lie directly on the Wild Coast of the Eastern Cape. Enclosed by the boundaries of the sea, the area stretches inland for about 16 miles. The majority of people in these villages belong to the *AmaBomvana* tribe. This area is sometimes called *Bomvanaland*. The *AmaBomvana* tribe spreads over two-thirds of Elliotdale district and includes the neighbouring Mqanduli district. *Bomvanaland* has numerous rolling hills, meadows, rivulets and rivers where bushes and trees grow. The roads are laid with gravel and have *dongas* [large potholes]



Source: Mji.[1]

FIGURE 4.1: Map of part of Elliotdale, showing the Madwaleni Hospital, the eight surrounding clinics, the villages, Mbhashe and Xhora rivers and part of the Indian Ocean.

that make travelling by car difficult. Spring and summer bring reasonably high rainfalls that assist subsistence farmers with green pastures that double up as grazing fields for their livestock (cattle, sheep and goats) as well as growing sites for *mielies* [maize] and vegetables for family use.

This district was purposefully chosen for the study for the following reasons:

- The predominant cultural group is the Xhosa who still hold onto their cultural values and norms.
- Because of the high levels of illiteracy, the researcher presumed that there will only be a low level of influence of Western approaches on health management.
- There is one district hospital and eight clinics in this area, and the researcher wanted to study the impact of this on the health practices of the older Xhosa women and the use of IHK.[13]

- There is a good spread of villages, with some being in close proximity to the hospital and others being far away. For the researcher, it was important to see the impact of these distances on the IHK carried by the older Xhosa women.[13]

Figure 4.1 presents the map of a part of Elliotdale, showing the Madwaleni Hospital, the eight surrounding clinics, the villages, Mbhashe and Xhora rivers and part of the Indian Ocean.

Key aspects of *AmaBomvana* culture that impact this study

Education

Education has managed to depolarise the *Amabomvana* into two groups:

1. the 'red' illiterate people (*amaqaba* = people who paint themselves with red ochre and are classified as traditionalists)
2. the 'school' people (*amaqhobhoka: abantu basesikolweni* = people who have left the traditional way of life and are usually Christians and to some degree are Westernised[14,15]).

Social position in the tribe

Status in the tribe depends on three factors: birth, sex and age. The man plays the dominant role in tribal life. However, a paternal grandmother may enjoy an authoritative position in her *kraal* and can give instructions regarding the type of healthcare to be used beyond the home. The tribal custom of *ukuhlonipha* refers to the respect people must show towards those of a specific age, sex and birth class. The culture of *ukuhlonipha* embraces:

- the respect of the young towards the aged
- the avoidance of the cattle kraal and of the male side of the hut by women, causing them to make a wide detour in and around the hearth
- a linguistic way of talking whereby a woman is not allowed to utter the name of her husband or the names of the male ascendants of her marital home.

Socio-economic life

The *Bomvana* are pastoralists and agriculturists. Their economy is interwoven with social and religious life. The possession of land and cattle, for example, is necessary for full participation in the social and religious life of the tribe. The density of cattle in *Amabomvanaland* is the highest in the whole of the 'old' Transkei. Today many *Bomvana* families live below the poverty line, and migratory practices have eroded the stability and backbone of the family unit.

Disease patterns and health conditions

In the past, three main health conditions in children were treated at hospitals: diarrhoea, pneumonia and malnutrition. More recently, tuberculosis (TB) and HIV are also being commonly treated, along with conditions that include vitamin deficiencies, anaemia, measles, whooping cough, bilharzia and injuries from trauma and burns. With adults, a number of cardiovascular diseases and some forms of cancer that usually present at a late stage are found. Most children are born at home, and it appears that there are more toddler deaths than infant deaths. It appears that the post-weaning stage is the most critical period in the lives of children.[14]

Rituals and ancestors

The *Bomvana* feel that they are totally dependent on their ancestors in all vital aspects of life: procreation, cattle and other property, as well as in the 'being' of the family as a whole. According to the *Bomvana*, *UThixo* [God] existed from the very beginning and emerged from the sea. *UThixo* was the first ancestor from whom the people originated. God was brought to bear by the *Amabomvana* when they needed a way of filling in the gaps in their knowledge. This filling up of the gaps with God also happens when a relative is sick and they do not have knowledge of the sickness nor the skills to help him and so use the hospital as a 'last resort'. It is perceived that this is because of the fact that the hospital itself was a mission

hospital and the *Bomvana* related to the care at Madwaleni Hospital as being similar to praying.

The relationship with ancestral life in *Bomvanaland* is the ultimate concern to which all social aspects of life can be referred. It is not only a social phenomenon but also a religion, a religion of great social importance. Ancestral religion is not a compartmentalised concept to the *Bomvana*, 'It is life to the African thought'.[15] This is expressed in the welfare of the group and is of greatest concern to the indigenous health beliefs in the tribal system.[15,16]

Researcher's community entry and development of community partnerships

1. *Meeting with the chief of the 18 villages of Gusi* (throughout this study, he will be called the chief): The outcome of the discussion between the researcher, the chief, his chieftains and the paramount chieftainess reinforced the information in Chapter 1 of this book, regarding the *Amabomvana* tribe, and it was confirmed that the *AmaBomvana* tribe still believe strongly in rituals and ancestors. The emerging themes showed that these three leaders were very much aware of the challenges facing the *AmaBomvana* people and their health. They were concerned about the lack of integration of their knowledge into mainstream healthcare, and saw this as a disjuncture with regard to health. There is a general perception that Christian religion, education and health systems have undermined the IHK held by the *AmaBomvana* people. Major areas of concern and health challenges included TB, HIV and AIDS; the emergence of new challenges such as abuse of liquor; and the change of governance from the chiefs being the sole custodians of the rule of law and the emergence of counsellors linked to central government. The *backwards and forwards movement suggested* by one of the chieftains as a solution to the health problems facing the *AmaBomvana* tribe needs further exploration.

2. *Meeting with the superintendent of the hospital and getting permission from him to implement the study:* The superintendent saw the value of research as a tool to improve health services. He was concerned about the relationship between the hospital and the people of Gusi. He was aware of the challenges and seemed to have a plan to address these. He and the matron were proud of their achievements regarding the therapeutic management of HIV and AIDS. This meeting with the superintendent included a discussion with the retired clinical nurse practioner, named Sister A in this book. Sister A appeared to be the liaison between the hospital and the people of Gusi. She assisted with the cultural context of the *AmaBomvana*, including assisting with an understanding of the 18 villages of Gusi. She also assisted the researcher with methodological adjustments that the researchers needed to implement. She further suggested that the researcher should not have focus group discussions (FGDs) for the elite older Xhosa women, as they do not like sharing their knowledge with other people. She suggested that interviewing them on their own was a better strategy.

Initial steps to ascertain and confirm methodological rigour

The methodological rigour was ascertained through responses from the five older Xhosa women (aged between 65 and 75 years) in the rural areas of Buntingville and Mdizeni. The older women were chosen by the principal of the secondary school of the area.

The process of ascertaining the methodological rigour of this study took 2 days. A social science student assisted as a scribe. With regard to the research tools and the process of data collection, the researcher piloted the exact method for storage, transcription and data analysis that she was going to use in the actual data collection.

Aspects that emerged from the process of ascertaining rigour

The following aspects emerged and their impact on the research was evalutated:

1. The five older Xhosa women described the health problems they managed at home from a broad perspective of daily living, beginning with assisting the grandchildren in preparing for school, engaging in daily activities from breakfast to supper, planting of the gardens and ending with ensuring that the grandchildren were all asleep and safe. It thus became evident that the older Xhosa women were using a broad approach and definition to health and sickness of the home. This approach is similar to how indigenous peoples define health and illness.[17] From this, the researcher began to understand the disease prevention and health promotion strategies used by the older Xhosa women. As the government struggles with how to implement the broad primary health strategy, the methods used by the older Xhosa women could be used as a case study to learn how to implement this strategy, including how to support the older Xhosa women as they quietly implement this strategy in their own homes.
2. Distances from the health services appeared to have an impact on the health-seeking behaviour of the people. One older woman who lived close to the health facility did not want to speak about her use of IHK to manage health and illness in the home and kept saying, 'we no longer practice those things'. However, the researcher observed that although she denied using IHK management strategies, she was determined that when it came to certain conditions, she would not want her children to go to the hospital, for example, to give birth. She saw her methods of assisting her children to give birth as being better than those carried out at the hospital. The issue of the impact of distance from the health facility on the health-seeking behaviour increased the researcher's awareness that when selecting participants for

the focus groups (FGs), she needed to include people who were at various distances from the health facility – both near and far.

3. As the researcher was conducting in-depth interviews with each older Xhosa woman, she noticed that the grandchildren and daughters-in-law kept giving their input on how the older Xhosa women supported the health of the family. One daughter-in-law affirmed the trust she has in her mother-in-law in assisting her to give birth. This further affirmed that the researcher should get inputs from family members to improve the rigour of the findings of the study.
4. The five women in the pilot study had good clarity on health management strategies in the home situation, and this affirmed that the elite older Xhosa women should be included in this study.
5. During one in-depth interview with one of the women (who had vast knowledge of IHK), a second older Xhosa woman later joined the conversation. The researcher noticed that the first older Xhosa woman who appeared knowledgeable about IHK became less talkative and less willing to share her knowledge once we were joined by the other older Xhosa woman. This finding is similar to the study conducted by Bell[18] amongst Aboriginal women in Australia. This confirmed the advice given by Sister A about the need to interview the elite older Xhosa women alone and not in an FG as they do not like to share their knowledge. One of the older Xhosa women ended her discussion by calling for the return of *undalashe* – which in this context meant the old ways of keeping respect, cohesiveness and the stability of the villages.

Selection of participants for the study

Study population

The study population was made up of two groups, namely, (1) all the older Xhosa women above the age of 60 years and (2) family

members of all the older Xhosa women above the age of 60 years from the 18 villages of Elliotdale.

Study sample and sampling methods

The 18 villages of Gusi functioned as clusters from where participants were selected. The four clusters that were used to select participants were organised from the 18 villages, with some village clusters being closer to the hospital.

The study sample was further divided into:

1. primary study sample: the older Xhosa women that formed the four FGs
2. secondary study sample: the elite older Xhosa women and their family members to understand why the elite older Xhosa women are trusted by their families and the community
3. transitional opportunistic conversers (TOCs): to demonstrate how changing mores in community life are exerting a strain on the elite older Xhosa women to practise their healing vocation.

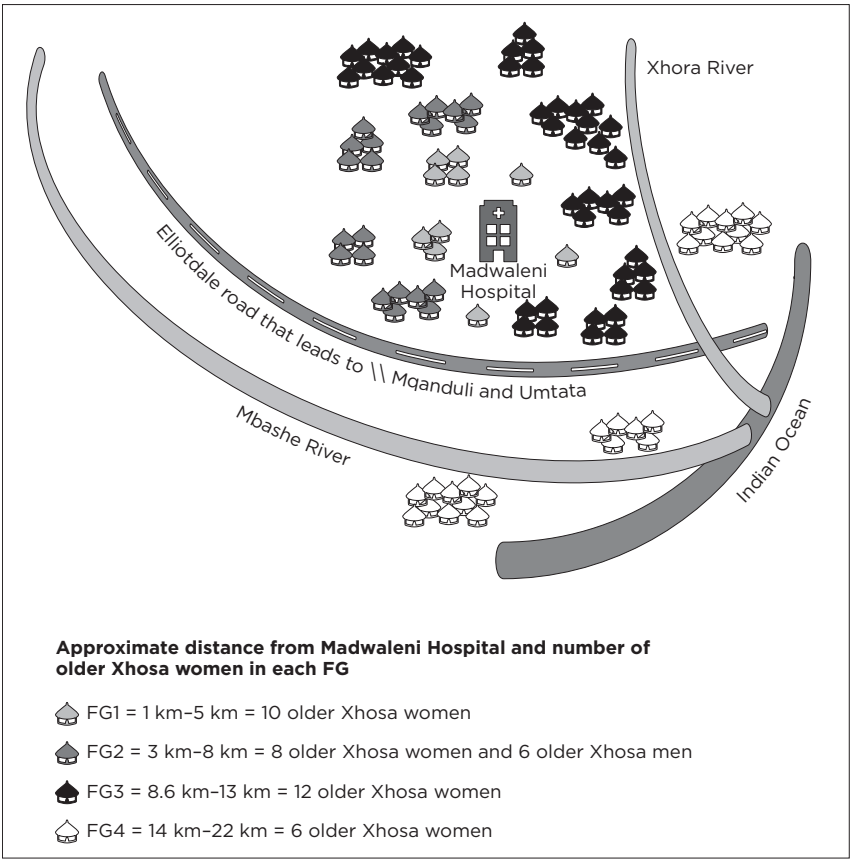
The primary study sample

The primary study sample comprised 36 older Xhosa women aged above 60 years from the villages in the study setting who were purposefully selected and voluntarily participated. Firstly, the chief selected the older Xhosa women from the 18 villages and the researcher then listed their names. Snowball sampling was used in which these older women identified others who could participate in the study. The main inclusion criterion was that participants should be over the age of 60 years and should be current residents of the villages. The pattern followed was as follows:

- The first cluster of four villages included the 10 older Xhosa women.
- The second cluster of four villages included the eight older Xhosa women and the six older men. These six older Xhosa men arrived at the FGD after getting to know that there was a

project on health issues, so it was difficult not to include them. It was also clear that with the inclusion of these men, this FGD would manifest unique characteristics.
- The third cluster of five villages included the 12 older Xhosa women.
- The fourth cluster included the six older Xhosa women.

Figure 4.2 demonstrates a schematic presentation of the selection of the older Xhosa women from the main study area.



Source: Mji.[1]
FGs, focus groups.

FIGURE 4.2: The four FGs of the older Xhosa women from the 18 villages of Gusi.

Selection of the secondary study sample

The secondary study sample comprised key informants to validate the findings from the primary sample. These consisted of the following.

Sixteen elite older Xhosa women. The elite older Xhosa women were identified in the following manner – from the two clusters of villages furthest from the hospital, four of the elite older Xhosa women participated in the FGD with the older Xhosa women. They seemed to be trusted by the other older Xhosa women as elite carriers of IHK. From the cluster of villages directly close to the hospital, three women were identified by the research assistant, while one woman had participated in the FGD. From the cluster of villages further away from the hospital, one elite Xhosa woman identified herself, another was identified by the lecturer from Stellenbosch University (SUN) who had worked as a doctor at Madwaleni Hospital for more than 5 years. In addition, five of the older Xhosa women from the pilot study in Buntingville and Umdizeni were identified as the elite older Xhosa women, as the principal of the secondary school in the area had chosen them for their renowned knowledge and experience in IHK and the fact that they were consulted by the other older Xhosa women in the village for this knowledge. The researcher also classified Sister A as an elite older Xhosa woman for her knowledge and contribution to the health problems that are managed by the older Xhosa women in their home situation. This brought a total of 16 elite older Xhosa women.

Four purposefully selected family members of the elite older Xhosa women. The rationale for selecting this sample was to find out who was consulted when a family member was sick, and why. Those selected were family members of the elite older Xhosa women who were willing to have the researcher approach their family members to participate in the study. The target sample included the daughters and daughters-in-law of the elite older Xhosa women and the grandchildren of the older Xhosa women.[9]

Transitional opportunistic conversers. While driving around the villages, the researcher would meet certain individuals who fit into the layers of the study. She would give these individuals a lift, then introductions would happen. Next, the researcher would explain why she was there amongst the 18 villages of Gusi. Then these individuals would start a dialogue regarding the research topic. These conversations brought unplanned insights into the complexity of the research topic. This approach is similar to the process of networking described by Webber[19]. He maintains that as human beings, we have the past, the space in between and the future. His perception is that the space in between is the most critical space for developmental work, as it gives one another insight that is different from the past and still not yet in the future. Networking capitalises on this space in between. These transitional opportunistic conversations were never asked to contribute anything to the research question. The introductions became the instrument that linked them to the research question. They tended to provide another perspective to the research question and reminded the researcher of the complexity of the research question. Below is the list of the TOCs; for this chapter, the following encounters will be presented:

- Transitional conversation 1: Two young wives (the *makotis*).
- Transitional conversation 2: Retired clinical nurse practitioner.
- Transitional conversation 3: Concerned clinical nurse practitioner.

Tools and data collection process

Tools and data collection proceeded along the two main lines:

1. Primary study sample: FGDs with the 36 older Xhosa women using an interviewing schedule.
2. Secondary study sample: *Elite older Xhosa women* – individual in-depth interviews using an interviewing guide; *family members of the older Xhosa women* – the narration of life stories of elite Xhosa women; and *transitional conversers* – introductions elicited conversations regarding the research topic.

Data collecion process for the primary study sample

Using an interview schedule, four FGDs were conducted with the 36 older Xhosa women, who were deemed to be carriers of IHK. The interview schedule that had been used in the pilot study in the rural area of Buntingville was used. It focussed on the main objectives of the study.

In each FG, the women knew each other as they were from the same clusters of villages. All FGDs were conducted in the homes of the older Xhosa women except for the first FGD, which was conducted in one of the chieftains' house. Each discussion varied with regard to participants' responses to the research questions. Distances from the health facility tended to have an impact on this variation.

Data collection process for the second study sample

The tools and data collection process comprised the following.

In-depth interviews with the secondary study sample. The researcher conducted individual, in-depth interviews with the elite older Xhosa women and their family members to affirm the findings from the primary study sample. The 16 women regarded as the elite group were interviewed in their own homes. While the initial plan was to conduct FGDs with each group made up of four elite older women, Sister A discouraged this methodology as she felt that these women were highly secretive and would not want to reveal their knowledge in front of others.

The elite older Xhosa women were asked to narrate their life stories in terms of how they had learnt about IHK and ultimately became renowned for their ability to treat illnesses and ailments. The researcher facilitated the discussion and prompted them to speak about turning and pivotal points in their lives that further consolidated their knowledge.

Individual interviews with family members of the secondary sample. The elite older Xhosa women were more open to their families being asked questions regarding how they managed health problems within the home situation. The researcher conducted individual interviews with the daughter-in-law of one of the elite older Xhosa women, as well as a granddaughter, a grandson and a granddaughter from another household. Each family member was interviewed in their homes. Two main themes informed these interviews: Who is the person that is consulted when somebody falls ill in the family and for what ailments are they consulted? Why is this person usually consulted, that is, what attributes does this person have which contribute to him or her being consulted?

Ethical considerations

Prior to conducting the FGDs, a consent form was verbally explained to them – as the majority of participants were illiterate or had low levels of education. They verbally accepted the conditions of the consent form. The process of explaining ethical considerations was undertaken in all interviews. In the case of minors (the grandchildren), consent was obtained from either the parents or the grandmother if the parents were not present. The study is registered with SUN's Human Research and Ethics Committee (registration no.: 2002/C047).

Process of data collection

A comfortable atmosphere was created by the researcher and her two assistants.[11] The participants were given time to discuss issues until they had exhausted the discussion and come to a conclusion. From this process, the researcher was able to contextualise perceptions and opinions; develop a plot to describe the full setting and character of the phenomenon under scrutiny;[20] describe roles and responsibilities, that is, analyse the positions that people occupy and the behaviour associated with those positions, specifically, the positions of the elite older Xhosa

women in the family hierarchy and the rationale for suggesting that they would be the first to be consulted when anyone had a health problem in the home.[9] The research assistants manually transcribed the tape-recorded interviews word for word in Xhosa (as this was their mother tongue and made it easy for them to document the information). The researcher transcribed these notes into English with the research assistants filling in the gaps where necessary.

Trustworthiness during the collection of indigenous research data

For this study, trustworthiness of data included the following areas: limit one's adverse effects on participants, credibility, transferability, dependability and conformability.[20]

Limit one's adverse effects on participants. The researcher was aware and sensitive to the unequal position of power she held in relation to the participants during FGDs. The researcher was careful about framing the questions and avoided leaving the participants with 'yes' or 'no' options of answering. The researcher also listened more and said less, thereby giving the platform to the older Xhosa women to find their voices and express themselves.[22] The flexibility to explore unanticipated issues about health and illness and how this is managed within the home situation by the older Xhosa women gave rise to the exploration of unanticipated issues such as poligamy and its impact on the health of the home and the older Xhosa women. This gave the results a high-profile affirmation.[10,21]

Credibility of data. Combined prolonged engagement during FGD and member checking – during the FGDs, the researcher continued to gather data until saturation was reached. With regard to member checking, the older Xhosa women would engage in discussions regarding a certain concept. They had a tendency to go round and round until they would all agree on each and every concept. On the other hand, when the researcher

further observed this process, she discovered that there was an element of affirmation for each other, and with this affirmation another new point would emerge, which would again be subjected to the same process, affirming this new point and continuing until full agreement again had been achieved.

Member checks to interpret initial findings. This occurred after analysis of data where the participants were given an opportunity to engage with the interpretation of findings. This was done as follows: 6 months after data collection, a feedback workshop was conducted for each FG to ensure affirmation of the data, to fill in any gaps and to share initial findings with the participants. Not all the women who were present for the first FGDs could attend the feedback workshops. Attendance was as follows:

- In the FG closest to the hospital, three of the older Xhosa women attended.
- For the FG that was second closest to the hospital, four women attended.
- For the third furthest away from the hospital, six women (instead of the original 12) attended.
- For the one furthest from the hospital, two women attended.
- Six elite older Xhosa women also affirmed the findings of this study during feedback workshops. The researcher read out to the elite older Xhosa women the list of health problems and the strategies, including medications that were mentioned by the older Xhosa women from the four FGDs. The elite older Xhosa women affirmed these lists but further cautioned the researcher of certain approaches and medications to certain health problems as they felt these approaches were very aggressive. They have an impression that, lately, the immunity of people is very low and for these conditions the best approach is to take the person to the hospital.

Dependability and conformability. This was achieved through peer debriefing, assisting with the process of examining all documentation and processes, and acting as an auditing process. A qualitative researcher skilled in performing and analysing qualitative studies assisted with the review of raw data, data reduction and data analysis products, data reconstruction and

data synthesis products, process notes and the researcher's daily journal. According to Babbie and Mouton,[22] if the auditing process is managed adequately, it can be used to determine dependability and conformability.

Other methods used to affirm the rigour of data were *transferability, link with qualitative experts* and *triangulation*.

Transferability. Thick descriptions of extensive field notes were taken on the environment in which the study took place. This needed to be aligned against the researcher's original theoretical ideas to highlight and indicate observations that may contradict the researcher's assumptions.

Link with qualitative experts. In the final stage of data analysis, a skilled qualitative data analyst checked the agreement between themes.

Triangulation. This was achieved using different samples to validate the main study findings.[22,23] The process of triangulation explored the phenomenon of management strategies used by the older people from different angles so as to gain more understanding and clarity, as well as why the older Xhosa women were consulted when a family member was sick.

Qualitative analysis of findings

The data analysis comprised an informal, ongoing stage of data analysis within data management, as well as a formal stage of data analysis.

Informal ongoing stage of analysis of findings within data management

Data analysis is the process of bringing order, structure and meaning to the mass of collected data. It is a messy, ambiguous, time-consuming, creative and fascinating process and does not proceed in a linear fashion. Qualitative data analysis proceeds in

search of general statements about relationships amongst categories of data through to ultimately bringing forward a grounded theory.[8,10,11]

Gold[23] maintains that in ethnographic research, rather than relying on a preconceived framework for gathering and analysing data, ethnographers use their interactions with informants to discover and create analytical frameworks for understanding and portraying that which is under study. Early in the research process of this doctoral thesis, the researcher developed an analytical strategy that meant ongoing analysis throughout the different stages of the study. Hence, observational strategies were adjusted, and the emphasis was shifted, tested and re-tested to avoid bias. Categories that characterised the older Xhosa women's strategies for the management of health problems were identified. These categories, together with the selection of conceptually intriguing phrases from the audiotapes, assisted in suggesting patterns. From these patterns, the researcher could start to draw up tables based on the key themes of the study objectives. From these, further key themes started to emerge, and the data started to develop its own direction.

☐ Formal analysis of findings

During the analysis process, the researcher tried to reflect on her own biases and tried to separate and draw boundaries around these before interpreting the data so as to prevent influencing the data with her assumptions. Transcriptions from the FGDs and the interviews were read and re-read until the researcher comprehended what the speakers were saying and was able to examine how individuals were experiencing the topic. From the text, a list of significant statements expressed by the participants was drawn up. These statements were grouped into 'natural meaning units'[19] expressed by the participants. (Meaning units are essentially those statements that are seen to elucidate the research phenomena.) These units of meaning were grouped together according to areas of similarity and dissimilarity.

Each meaning unit contained a distinctive and unique idea. Once the meaning units were grouped, they were further analysed to discover specific similarities in meaning to form 'clusters of themes'.[11] Each category was developed into a textual description, which elucidated what the older Xhosa women saw as health and illness within the home situation. This included the determinants of health and illness, as well as strategies they used to manage the health problems.[8,11]

Categories were examined in conjunction with the raw data (from which the categories were derived) in terms of the specific purpose of the study. To clarify, the researcher needed to ask the following question: What does this statement reveal about the research question? In the context of this study, this related to how the older Xhosa women viewed health and illness, as well as how they managed health problems within the home situation.

While formulating categories from the meaning units using the transcribed responses, the researcher needed to identify only those units that pertained to the purpose of the study, namely, the IHK carried by the older Xhosa women for the management of health problems in their home situation. This process required a substantial amount of intuition and judgement on the part of the researcher. The categories were weighed against the research questions and subsequently further analysed and interrogated, resulting in a process from which 'central themes were determined'.[19] These themes were extracted from all the categories emerging from the participants' experiences. This allowed for common themes to unfold from the experiences of all participants pertaining to the phenomenon under scrutiny.

The final stage of analysis was *narrative analysis*.[19] This step involved the grouping of themes. The aim was to assemble the essential, non-redundant themes and to formulate a descriptive statement, which captured the 'essence of meaning units within the holistic context'.[8] In this phase of analysis, the researcher incorporated all the themes extracted from the FGDs and the in-depth interviews into one summary. This process assisted in

constructing biographies and could be understood as the 'second level' of analysis.

Biographies were constructed in such a way that they could foreground the life plots with regard to health, illness and the health problems that the older people managed within the home situation. These elucidated turning points for the older Xhosa women as managers of health problems within their home situation. Therefore, the development of themes was informed by categories that emerged during the first and the second levels of analysis. This put the data into a holistic context that essentially reconstructed the inner world of the participants' experiences.

The biographies presented certain events, actions and happenings pertaining to the healing practices of the older Xhosa women. Their engagement with health and illness was organised into plots, from initial entry into IHK, to understand what health and illness is and the events that undermine health. These formed a part of the narrative analysis.

According to Denzin and Lincoln,[20] the ultimate goal of qualitative research is to produce a research report that gives an accurate, clear and articulate description of an experience. The reader should come away feeling, 'now I understand better what it is like for someone to experience that'.

Concluding statement

The proposition made in Chapter 1 was that the older Xhosa women use IHK for the management of health problems in their home situation. The initial affirmation of the rigour of the methodology that was implemented in a rural village in the Eastern Cape province confirmed this proposition and what the study aimed to achieve by exploring the IHK of the older Xhosa women residing in the Eastern Cape province. This gave the researcher confidence that the methodology to be used in the main study would help achieve the primary and secondary objectives of the study, as the older Xhosa women consulting for

the affirmation of rigour not only provided an understanding about IHK but also wanted to know how this knowledge can be revived. They also added some suggestions such as going back to *ndalalshe* [old traditions and values systems] during the discussions.

The response of the study sample during the collection of data reassured the researcher of the relevance of carrying out an enquiry of this nature, such as the process of affirmation of rigour, as they were able to respond sufficiently to the objectives of this study.

Chapter 5

Critical study outcomes and the proposed primary healthcare model

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Introduction

This chapter provides an overview of the presentation of findings, assisting the reader in understanding the additional findings that were presented as results but were omitted from the chapter on critical research findings during the first presentation of the PhD study. The chapter follows with an acknowledgement of the process as the vehicle that propels and unlocks critical research findings in qualitative research; indigenous people's observation of the natural world as a type of science is explained; the struggle

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for South Africa to implement comprehensive PHC is given; the contribution the chief of the *Bomvana* in conceptualising and theorising what has caused ill-health in their communities is given. A backward and forward movement by Chieftain Tinky-Penny is explained; the discovery of the elite older Xhosa women – a philosophy of healing and carrying with humility and without duress is given; recognition of the home – a complex terrain where health is maintained and ill-health is declared is presented; the emerging model of the definition of health and sickness by the older Xhosa women is given; relationships and *umoya* (the spiritual element) – the ultimate cause of health and sickness – is explained; using functionality as a yardstick for wellness is given; the health problems that are managed by the older woman within the home are explained; the caring attributes of the older Xhosa women and the circle of caring of the older Xhosa women is highlighted; the rural PHC model envisaged for the 18 villages of Gusi is suggested; the chapter ends with a concluding statement.

An overview on the presentation of findings

This book, though based on the initial findings of the PhD study, has given me the opportunity to integrate some of the research findings that were omitted in the presentation of initial critical findings but were part of the findings' chapter and discussion.

An outline of some of the rationale for including these findings as critical findings has been further discussed.

Acknowledging the process as the vehicle that propels and unlocks critical research findings in qualitative research

In qualitative research, the process becomes the vehicle through which critical events and actions take place. Maxwell,[1] quoting Merriam, states that 'the interest [in a qualitative study] is in a

process rather than outcomes'. The process of qualitative analysis for this study continued even beyond the submission of the PhD thesis. Similar to indigenous peoples and the lens they use in understanding health and illness, the process theory deals with processes that connect events; it is based on an analysis of the causal processes by which some events influence others. This approach then assisted me to continue analysing the findings and the implications they have for the key research question which is: What is health and illness according to the interpretation of the older Xhosa women and how do the older Xhosa women manage the health problems in their home situation using an IHK approach?

Process reasoning as an instrument to unlock marginalised knowledge

Linked to the continuous process of data analysis is process reasoning, which, in qualitative research, provides answers as to why aspects are the way they stand. This approach and the strength of a qualitative study coincides, firstly, with the broader understanding of a majority of the indigenous people of the world regarding health and illness[2,3] and, secondly, it resonates well with how health and illness are explained by Africans using process reasoning, with the individual being seen as part of and interacting with their context. Maelene[4] further explains that when it comes to health and illness and an African interpretation of these, contexts and processes become critical. From the context and process of the actual events that led to health or illness follows the quest to understand illness by way of questions such as, 'why?' and 'who?' Entering the research community with this understanding enabled me to view the community stakeholders as the holders of indigenous knowledge who must be given an opportunity to explain critical events that answer the research question from their perspective, thereby allowing them to be co-creators of knowledge that affects their lives. It is with this approach in mind that I saw myself as a

researcher who, having entered a space of learning, had to allow the village and its stakeholders to guide me in understanding my research question in its totality; hence, the inclusion of findings that were not initially presented as critical research findings.

Indigenous people's observation of the natural world – A type of science

Brian Swimme[5] speaks of moving away from being hand maidens of modern technology by drawing from indigenous peoples who use observation as part of solving problems in their daily lives. He further explains that we need to start seeing this observational approach of indigenous peoples as a type of science. The movement of science has been one of mathematising knowledge. Indigenous knowledge, by linking events and history, puts itself in a leadership position in natural history. This is because of centuries and centuries of building a body of knowledge from direct observation, assisting others in sharpening their lens in developing a consciousness of direct observation and cherishing of local knowledge. With this observation science, they were able to feed their families, understand astronomy, predict and direct rain and use medicinal plants to heal their families when they were sick. As the knowledge of the indigenous peoples is stored in the brain with constant affirmation of its reality, it carries the most affirmed knowledge. With observational knowledge, there is a complete connection with the whole based on a vast collection of observational knowledge taken altogether, thereby giving one wisdom of understanding how events have influenced each other to give the results seen. This again relates to Maelene's[4] concept of how Africans view health and illness. Drawing from the concept of process reality and combining it with observation and listening to key stakeholders, this further encouraged me to present findings that were initially not seen as critical research findings.

The struggle for South Africans to implement the comprehensive primary healthcare strategy

There is a global historical perspective on how it has been a challenge to implement the comprehensive PHC strategy that was coined in Alma Ata in 1978. After 1994, there had been attempts by the South African health department to implement the comprehensive strategy of PHC. Clinics were built in areas where there had not been health services before to improve access to health services. Unfortunately, none of these attempts could improve access to health services for many South Africans, especially for those residing in rural areas. It appeared that many of these community-based services, such as clinics, still focussed on curative approaches that failed to focus on health promotion and disease prevention, as well as recognition of community-based assets such as IHK systems. This has resulted in health-seeking behaviour that views the existing primary health systems as spaces to solve all illnesses, including MHAs, for which communities have assets to manage at home. The initial critical findings suggested a rural health model, with the elite older Xhosa women playing a key role in the implementation of this model. Critical findings of this book have been further discussed.

Critical research findings initially not presented in the PhD study were:

- The contribution of the chief of the *AmaBomvana* in the development of a theoretical and conceptual understanding of the impact of externally imposed religion, education and allopathic medicine on the health of the *Bomvana* – the lamentations of the indigenous chief of the *Bomvana*.
- Recognition of the home as a complex structure where health processes are maintained and where sickness is first declared.
- The method of how the IHK carried by the older Xhosa women was developed and spread amongst the *AmaBomvana* people.

- The emerging of indigenous health scholars – the elite older Xhosa women approaching health from a philosophy and a science of humility and practising this without duress.
- The link between the indigenous people of *Bomvana* land, each with their lands and their animals.
- *Umoya* (spiritual element) – a driver of health and sickness.

In further staying within the boundaries of the aim of the PhD, which was to explore the health problems that were managed by the older Xhosa women in their home situation, with special focus on indigenous health systems, the following findings that were presented as findings for the PhD will also be presented in this book:

- the emerging model of health and sickness definition, from the perspective of the older Xhosa women, will include the use of functionality as a yardstick for measuring wellness
- the health problems that are managed by the older Xhosa women within their home situation
- a rural health model.

All these findings are presented and explained further.

Contribution of the chief of the *Bomvana* to an understanding of what caused ill-health in their communities

I met with the chief of the *Bomvana* through a key informant I was introduced to by the Superintendent of Madwaleni Hospital, as he saw *AmaBomvana* as a people of customs and rituals and was concerned that during community entry and my meeting with the chief I might overlook certain protocols, which might undermine my whole community entry and research. I did not expect the chief to engage with the study, but once I had shared with him the essence of the study, my perception was that the chief wanted to give his view on the research topic by starting to link ill-health of the community to foreigners who entered their

area and treated them as blank slates, ignoring the knowledge they held in the areas of education, health and religion. He theorised that this ignoring of the existence of prior knowledge in these three areas by the foreigners has undermined the health indicators of their quiet existence. He declared that they were/are people of traditions and rituals.

These cultural practises were deeply spiritual and followed a pathway that influenced every action they took. The *AmaBomvana* believe that the greatest indicator of good health is to live and exist as an embodiment of being *Bomvana*. To live and exist as *Bomvana*, there were certain factors and obligations that must be maintained, and these include the capability to plough the land and provide indigenous food for the family until the family reaches satiety; raising, supporting and educating children from conception until they become young adults who know and respect their culture and their spiritual pathways; living without strife and contention; and brewing Xhosa beer for participating in ancestral reverence to cultivate a relationship with God.

To the chief, *Bomvana* identity was first undermined by religion and then education. According to him, they were given bad education that undermined *Bomvana* traditions. He believed that Ministers of Religion and Schools, these two institutions, have destroyed people's cultures. They have confused the black person. Hence, the *Bomvana* were in a confused state (young people drinking beer with adults from dusk until dawn, children not respecting their parents, neglect of ploughing for food and neglect of spiritual reverence). According to him, church happens from inside the kraal/parameter of your household – the kraal is where you keep your cattle, and this is your religion. He further stated that the Bible was introduced wrongly by white people. Ministers quoted from the Bible and made the Bible God, whereas God was hidden – nobody knows who God is. According to him, there were many interpretations of who God is, but the Bible offers only one interpretation. One of his chieftains (as the chief cannot discuss matters of the village without the presence of these gatekeepers) who had joined him concluded by saying, 'we

are going back and nothing is going to help, we can only survive only if we adopt *a backward and forward movement*'. I asked, 'what is this backward and forward movement?'

A backward and forward movement by Chieftain Tinky-Penny

Chieftain Tinky-Penny explained that they (indigenous scholars) need to be allowed by those following modern culture and civilisation to go back and retrieve the good things in their culture and move forward with those and continue like that; whenever they encounter a new modern concept, they need to go back. Each modern concept must be underpinned by good old ideology. He said, before the implementation of the new concept, there was a need to connect the concept with the older traditional concepts to determine what should be integrated and what should be left behind, because of a lack of relevancy to the current development and what is required for tomorrow.

These two critical findings initially overwhelmed me. Here these two indigenous scholars were, firstly, theorising and conceptualising about what has brought ill-health to their communities; secondly, they were giving me a glimpse of their civilisation before foreigners entered their communities; and lastly, they were gifting me with a solution – *the backward and forward movement*. My initial response to these findings links with those of Serpell[6] and Mkhize[7] whereby they point to the creation of African elites, as mentioned by Werner and Sanders,[8] whose views and lifestyles are similar to their middle-class Western mentors and different from those of their own (indigenous) societies. As an indigenous person who has been actualised in Western education, I wanted to see the chief safely nodding at my research question and allowing me to explore my topic without any questioning, as I too have quietly assimilated without questioning the knowledge I was provided in the classrooms of modern education – an education that was promising me a better future than the one that I lived in my

indigenous rural environment, which was seen by modernity as not good enough. As the chief and his chieftain narrated their story, I could sense the ground I was standing on starting to wobble and shift.

Recognition of the home – A complex terrain where health is maintained and ill-health is declared

The rediscovery of this organisational structure, which has its own hierarchy, relationships, organisational norms and life, both obvious and also sometimes hidden or unspoken,[9,10,11] was an important event for the researcher as it reminded her what knowledges are born of and how the present institutions that had brought ill-health to *Bomvana* people (religion, education and health) were all encased in this organisational structure.[8] The home is also where personal and private matters, such as illnesses, are declared and contained, and the social determinants of health are practised and played out. Within the home, the older Xhosa women are involved in teaching the young about matters of health, including herbs and the culture of being *Bomvana*. The wives of their sons, which is the middle generation, also get educated about this culture, including the validation of their own knowledge. According to the older Xhosa women, healthy homes make healthy villages. To the researcher, it appeared then that, like the healing knowledge that was wrestled from the grasp of earlier women, the home too in *Bomvana* land had to relinquish its own knowledge in matters of religion, education and health in building the surrounding institutions, none of which drew from the culture and knowledge of *Bomvana*. According to the two male participants who later joined the FGs discussion of the older Xhosa women, they felt that women were mainly responsible for the strategies at home and, according to the older Xhosa women, all strategies of the home are health strategies. When I asked this FG as to what they were going to do about their lost IHK, as none of the participants wanted to speak about this, they said: ‘we need

to go back home', and when I asked what do they mean by this, they explained that: 'this is where it all got lost'.

This reminded me of a study that was presented in a SAAHE conference about the dropout rates of dental students, the majority of whom came from rural areas.[12] This study suggested that rural students, when they enter academic institutions, are in culture shock as it appears that academic institutions use the model of a middle-class white family in its design, which then favours white students. It requires the first-year rural students to settle down and recover from this culture shock.

The method of how the indigenous health knowledge carried by the older Xhosa women was developed and spread amongst *AmaBomvana* people

The Xhosa people organise themselves into clans. Over and above their name and the surname that they have linking them to their father's surname, they also have a clan name that links them to their father's clan and to the community at large. It is important to note that none of the women that participated in this study were married into the same clan, and that the majority were born in villages outside of Gusi and only came to Gusi after marriage. Such a system ensures that all villagers are always linked to a household; hence, it is perceived that one rarely finds homeless people in Xhosa villages, because of the said design.[9,10,11,12] In the past, marriages were not allowed to take place between members of the same clan, for fear that it would disable families.[8,10,11,12]

It could be expected, then, that even in other villages outside *AmaBomvana*, the same pattern of young women moving from their own villages to be married in other villages was the norm, as the Xhosa tradition tended to see all children from the same

village as belonging to all village households. In addition, villages were, most of the time, arranged in clusters of clans, and one was not allowed to marry somebody from the same clan.

When one observes the growth pattern of the young girls in their own villages who are tutored in health issues by their maternal grandmothers, and who later marry into another village and fall under the tutorship of the mother-in-law, one can observe a cyclic pattern of IHK moving from one generation to the next and from one village to the next. The IHK is entrenched in a Xhosa woman as she moves through the various stages of development of being a grandchild, a young woman, a daughter-in-law who will soon be a mother and finally a mother-in-law (with the process possibly including transferring a herb from one's own maternal village to the village into which one marries). The mother-in-law validates, approves and adds to the health knowledge possessed by the daughter-in-law, as she too bears her own template from her own grandmother and mother from her maternal home. It appears that this is how the IHK for the management of health problems within the home situation was developed and shared amongst the villages of the Xhosa households and the *AmaBomvana* tribe.[2,3,12] However, the breakdown of family units caused by the movement of younger people to seek work in urban areas means that the cycle will, ultimately, fall away.

The discovery of the elite older Xhosa women – A philosophy of healing practised with humility and without duress

An inquiry into the IHK carried by the older Xhosa women in *Bomvana* land revealed a wealth of health-related knowledge carried by the older Xhosa women in supporting their relatives when they were sick. It was further ascertained that these older Xhosa women, when their IHK strategies did not help in improving

the health status of their relatives, went out of the home to consult the other older women who are known in their villages for dealing with the particular type of illness. Mji[12] classified these women as elite older Xhosa women. Elite groups are composed of influential, prominent and well-informed people, who occupy important positions and whose behaviour is associated with those positions. They are expected to possess expertise, valuable information and an overall view of the social organisation in their villages. Mji[12] argues that the older people in indigenous communities such as *KwaBomvana* can become more powerful and autonomous in old age, taking on new roles and duties.

The older Xhosa women of *KwaBomvana* have excelled in the management of the health of the home by developing a bridge between natural indigenous herbs of their area and the home. Elite groups of people respond to questions about broad areas of content and display a high degree of expertise in taking a concept and theory and breaking them down to assess the practical implications of that concept. For example, the theorising and conceptualisation of the chief around foreign entries having undermined the education that the *Bomvana* carried. These women further broke this down to the continuation of slavery and the fact that their children were not entering the urban areas on an equal footing with their urban counterparts, but as slaves. To them, it did not matter how educated their children were. According to them, the urban areas are not offering the early building blocks that they could continue building their civilisation on; instead, they are giving them a readymade recipe. They further explained that buying food instead of producing food from their soil is equal to self-poisoning, and not eating food that has been fertilised by the placentas of the children of the village and their animal counterparts, including droppings from both animals and people, is like buying poison. The elite older Xhosa women seem to carry their knowledge for the care of the family and environment with some humility – they have strengthened the concept of 'humility', health and survival as a collective by

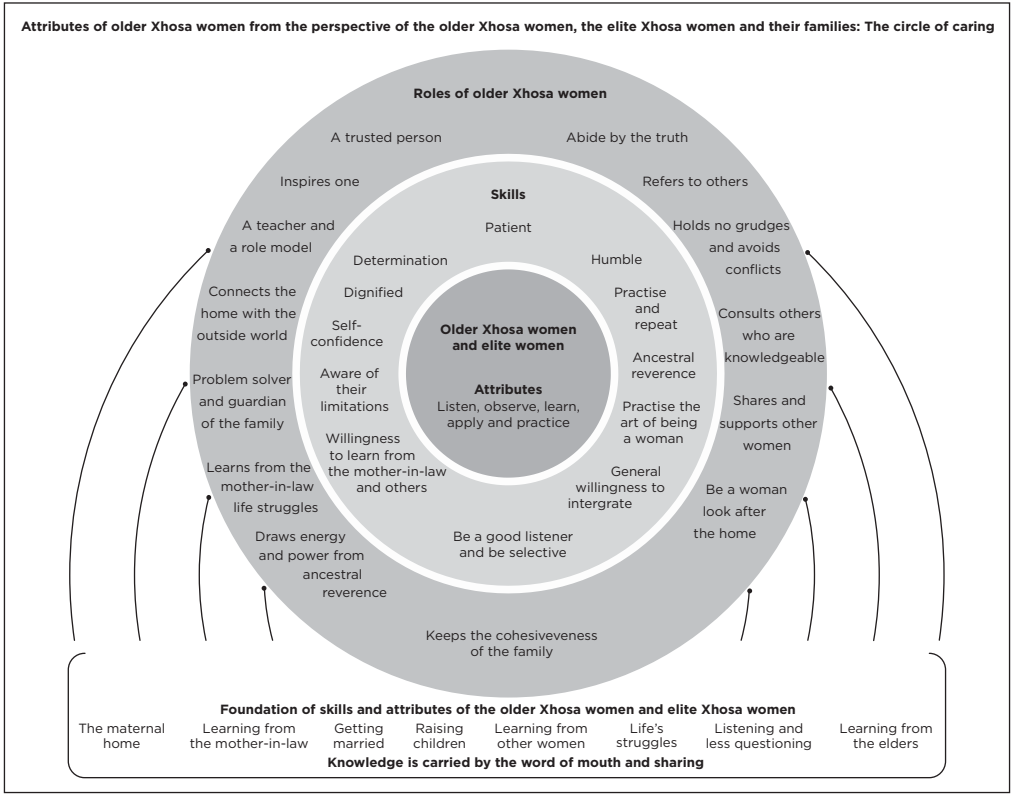
sharing their knowledge of healing practices with their community, and all of this appears to be practised without duress – *a philosophy of humility practised without duress.*

The caring attributes of the older Xhosa women and the elite older Xhosa women: The circle of caring

In describing the current study, it has been made clear that the older Xhosa women use a myriad of caring skills to ensure the management of health in the home. Such skills assist the older woman in her management of the health problems within the home. Figure 5.1 outlines the caring skills and attributes of the older Xhosa women in the study.

Figure 5.1 shows that the skills and attributes of the older and elite Xhosa women appear to be underpinned by the five components that are integral to knowledge and information exchange, namely, listening, learning, observation, application and practice. This implies that the knowledge regarding health that is carried by the older and the elite Xhosa women is always evolving. There is a process of listening, observation, learning, application and practice. The middle generation (consisting of the *makotis*) goes through a process of validation of the knowledge by listening to, and learning from, the mother-in-law. The holders of the knowledge (referring to the girl child who will be married into another village) are quite mobile individuals, transferring knowledge from one village to another village. The men of the village describe the women as the source of all the strategies in the home, unlike Westernised women, who practise such a role but also participate in the industrial world, resulting in their resources being spread quite thinly.[13,14,15]

Lately, the area of caring is a contested terrain requiring critical attention regarding who defines these differences as well as their practical implications. Feminist authors such as Cloyes[16] and Cockburn[17] challenge the notion of caring and see



Source: Mji.[12]

FIGURE 5.1: A flowchart showing the caring skills and attributes of the older Xhosa women.

it as being situated in inequalities within oppressive hegemonic arrangements of power. Others such as Dybicz[18] and Bradshaw[19] caution that true caring is usually underpinned by qualities such as democracy, reciprocity and collaboration. These authors see caring as important elements in the facilitation of health and well-being that the older and elite Xhosa women saw as their primary role. For the older Xhosa women, their roles as women were clear, namely, to manage and look after the health of the home. The current study has clearly demonstrated that, for the older Xhosa women, the role is starting to be a challenge, because of the introduction of Western medicine, and the changes that are happening in their family structures and in the community.

The link between the indigenous peoples of *Bomvana* land with their lands, their animals

Drawing from the observational process I was using, I noticed the connection of the *Bomvana* with their land. Their actions were always geared towards ensuring that there was a link between themselves and their lands. When a child is born, once the mother has recovered from childbirth, she is given the placenta to integrate it with the soil in her own private place. According to the older Xhosa women, *Bomvana* land is fertilised by the placenta of their children, the placenta of their animals and the droppings of both animals and humans. They believe that when rain falls, all these residues are drained to the bottom of the valleys and that is where herbs grow to heal the people of *Bomvana*. According to the older Xhosa women, everyone born in *Bomvana*, when they are sick, can be healed by a herb. They also believe that eating food cultivated in *Bomvana*, in one's own garden, is like eating a herb, and eating food that has been bought and not ploughed in their fields is like eating poison. The chief of *Bomvana* is concerned about high levels of alcoholism in the area –who is going to plough the fields when the young are drunk in beer halls?

The emerging model of the definition of health and sickness by the older Xhosa women

A clear definition of health and sickness emerged from the findings obtained in the study. Regarding the nature of health, the following issues are covered in the definition:

- the determinants of health
- the nature of sickness
- the determinants of sickness
- the use of functionality as a yardstick against which to measure health, wellness and sickness.

Definition of health and sickness

With regard to the definition of health, the older Xhosa women defined not only health but also sickness. If the communities are to uphold both health and wellness, they need to understand and to describe the other side of the coin, which is sickness.[2,3,19] The results from the current study included the definition of sickness as good health promotion and a strategy for the prevention of disease.[20,21,22,23,24,25] Communities can now get to know what they need to prevent in their communities.[18,19] This study, therefore, firstly suggests that, during the 2015 revision of the health definition, the World Health Organization (WHO)[26] should have also developed a definition of sickness to accompany the definition of health, as it is deduced from the results of the current study that the formulation of such a definition would lead to the further endorsement of health promotion and disease prevention strategies.

The older Xhosa women added three elements to the existing WHO health definition, namely: food security; healthy children and families; and peace and security in their villages. Secondly, the study proposes that the three elements mentioned should be included in the revision of the WHO health definition of 2015.[26] The three elements are not only important for the 18 villages of Gusi but also for the rest of humanity.[21,22,23,24] Finally, the study proposes

that a definition of health would need to be seen as a flexible entity that requires its final indicators to be clarified and developed within each particular context, with the aim of the people in the context being to take ownership of the definition. A universal health definition that lacks such flexibility is a drawback, as the health context of the people of the world is not universal, and, furthermore, the systems that are currently being used to determine health tend to follow the biomedical health system.[3,4]

The health approaches, as well as the definition that underpins the indigenous people of the world, have still to be considered.[3,4,27,28] By defining the degree of health and sickness present in their 18 villages, the older Xhosa women had started to make a clear contribution in this regard. South Africa is currently re-engineering PHC together with a new health plan. It is hoped that the three elements and the definition of sickness can be included when considering the rural health plan for the 18 villages of Gusi.[29,30] Box 5.1 outlines the critical aspects that emerged from the definition of health and sickness by the older Xhosa women.

When comparing Box 5.1 with the contents of the essential elements of PC and the essential building blocks for PHC,[18,19,31] it appears that some aspects, such as maternal and child health, nutrition, water and sanitation and diseases, are contained in both definitions. The older Xhosa women go further to describe the underlying social and economic determinants that cause poor health.[18,19] To them, it is about addressing the underlying social determinants of health that could assist them in reclaiming the health balance in their villages.

Relationships and *Umoya* (spiritual element) – The ultimate causes of health and sickness

Over and above the causes of health and sickness that are mentioned in Box 5.1, the older women were able to share a theory with me that links with Maelena[4] and Liddell et al.'s[32]

BOX 5.1: The critical aspects that underpin the health and sickness definition produced by the current study.

Definition of health	Determinants of health	Definition of sickness	Determinants of sickness
• Absence or presence of disease • Healthy pregnancy and healthy children • Food a key contributor of health to the home • Presence of peace, happiness, wellness and support for one another in the village	Positive: • Happiness and wellness • Connected to ancestors and God • Food production • Production of Xhosa beer Negative: • Presence of worry • Subject to being troubled by men/husbands • Subject to being troubled by children	Interpreted within a perspective that is both physical and emotional • Absence of the following: money; sanitation; running water and electricity • Migration of adult children to work in the cities	Doing poorly at maintaining the following: body; spirit; children; mother and other family members because of: • the absence of work • loneliness • the migration of children to the cities • substance abuse by children (smoking and drinking) • the inability to produce food and Xhosa beer • no time for ancestral reverence

Source: Mji.[12]

theory of health and sickness amongst African people whereby these two authors proposed that Africans always look for the ultimate cause of illness and that, for one to be well, this ultimate cause needs to be addressed and corrected. For the older Xhosa women, the ultimate cause of sickness is a broken relationship. They propose that when relationships are not working (whether with family, neighbours or the village), sickness starts knocking at the door. According to them, it starts with one person who is feeling anxious because his or her relationship is not working with whoever. This anxiety that has attacked that one person because his or her relationships are not working starts affecting the person and, as a result of this, the person carries *umoya ombi* [bad, toxic air/spirit]. This bad toxic air caused by anxiety

because of relationships that are not working at a personal level can make one sick, and the area that can first become sick is the weakest area of the body, as the older Xhosa women believe that we all have weak areas in our bodies. At a relational level, this person carrying bad toxic air can affect those close to him or her, resulting in them also being affected, and this could spread to the neighbours and at the village level. According to the older Xhosa women, wars are started by one person with an anxious unrestful air. To remedy the situation would involve remedying the relationships that have been broken. For the older Xhosa women, by the time you get to see the physical sickness, ill-health has been festering for a very long time, and at the core of sickness are broken relationships and a resultant anxious spirit. They were frustrated with the curative approach of the hospital – no one was asking about whether their relationships were working or not. Hence, even if they recover from illness and go back home, they still perform a ritual to link with ancestors asking for their guidance and protection, including how to mend the broken relationships. The perception of the older women of *umoya ombi* reminded the researchers of instances when you enter a meeting room where people cannot agree on an issue – we usually say, 'it was as if you could cut the air with a knife'. The question is: if these individuals are held in this room for a longer period while failing to resolve their disagreement, could this heavy air not lead these individuals to the next level, which could be actual physical fighting? We have seen this in the highest places of the land, both at national and global levels – parliamentarians breaking into brawls. The older Xhosa women postulate that this bad air, if not diffused and the person holding the bad air not healed, can lead to a war of global proportions. If we think about and trace global wars, there is usually one person unhappy about something. This unhappiness spreads until others are affected, and this continues until war erupts.

The question that needs to be asked is: Do health providers and health services have any role to play in *umoya ombi.* Is this

not some of the areas that indigenous healers focus on? The older Xhosa women see peace and security as one of the contributors to health and well-being – they also believe that fighting, especially within the home, causes ill-health within the home and the village, as happy homes make happy villages. Does PHC see a role in creating and sustaining happy homes and happy villages and creating *umoya olula*, *ococekileyo* [easy clean air], or does it prefer to catch the village dwellers with an ambulance at the bottom of the cliff once they have fallen?[33]

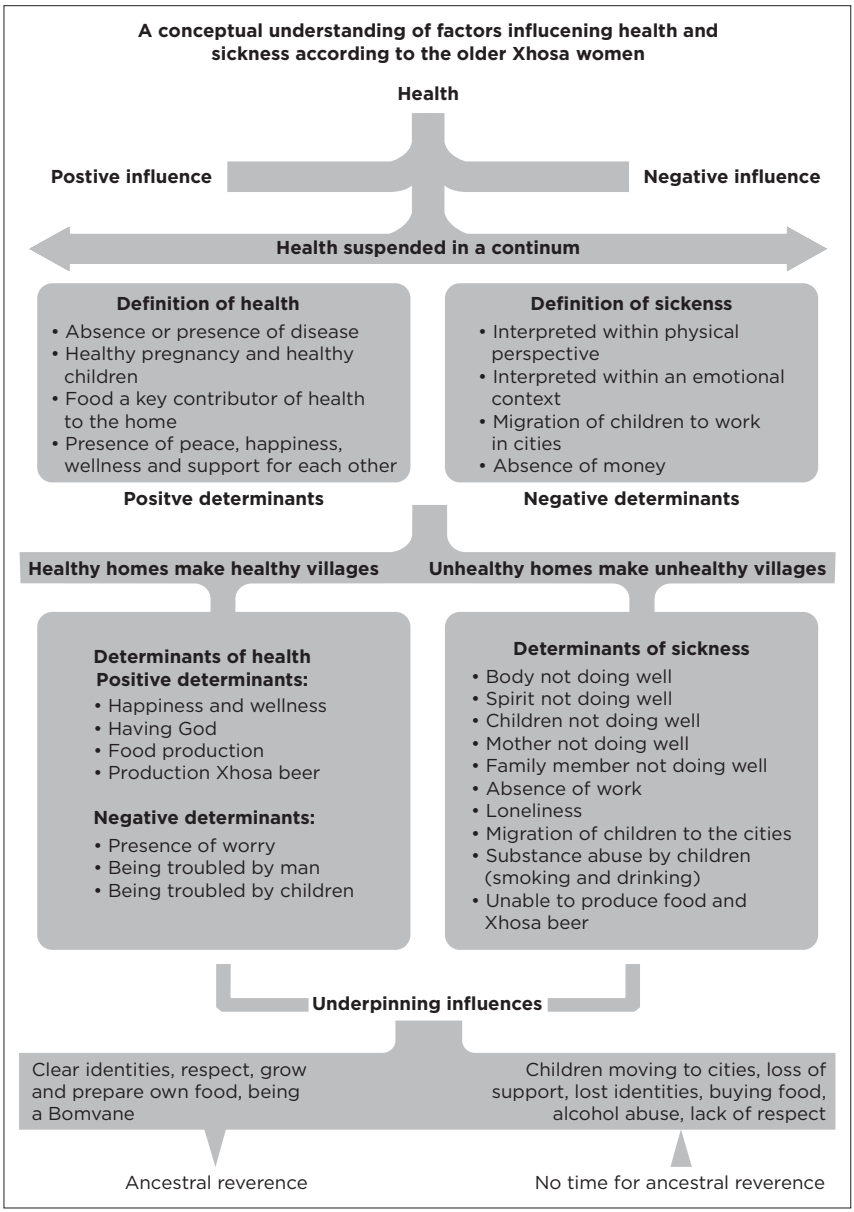
Using functionality as a yardstick for wellness

For the older Xhosa women in the study, like the Maori,[34] health was measured according to their participation in tribal activities, being included in family celebrations and the ability to make Xhosa beer for ancestral reverence.[28,31,35,36,37,38] Being healthy entailed being fully engaged in the functions of the *AmaBomvana* people. This is the yardstick that they used for measuring the health status of an individual in their villages. This concept is similar to that of the International Classification of Disability and Health (ICF), which proposes that the limitation of one's activities and one's participation is linked to both environmental and personal factors, and that the two factors will ultimately determine the status of a person's health and disability.[39] The challenge with the ICF tool is that, often, no consideration is given as to who the person is and regarding what identity she or he brings to their health status, whereas the identity is to be used as a yardstick for measuring the full community integration of the person. For example, when the older Xhosa women discuss going to work, consideration must be given as to what type of work an older or younger person, or child, in one of the 18 villages of Gusi does. The above aspect has huge implications for health professionals who are from

outside *Bomvana* land, and for those who are trained in Western medicine who do not understand the culture of the *AmaBomvana* people, including the enhancement of *Bomvana* culture by that person as a way of contributing to his/her health and wellness. This relates to Maelene's[4] suggestion that health promoters and disease prevention in rural South Africa need to be cognisant of the contribution made by culture to the health of rural South Africans.[40,41] Health professionals who are outsiders will need to understand the cultural implications of being *Bomvana* in order to be effective in health delivery in *Bomvana* land.[41]

This study also charts a new pathway for the rehabilitation profession. The World Health Organization defines rehabilitation as enabling disabled people to reach and to maintain their optimal functional levels by providing them with the tools that they require for attaining independence and self-determination. The ultimate goal of rehabilitation is full community integration.[42] The Medicine and Health Science Faculty (MHSF) at SUN is already sending final-year medical students to hospitals in the area. It is proposed that the MFHS should include, in the multidisciplinary and interprofessional student teams visiting the area, final-year students in the rehabilitation professions (i.e. physiotherapy; occupational therapy; speech therapy; and human nutrition), in addition to medical students.

Once the said students have become part of an integrated team for the revitalisation of PHC in the area, they will need to understand what the functions of being *Bomvana* are, and what are the key indicators for this level of functionality? Consequently, the indicators concerned will be used for rehabilitating their persons into the community on *Bomvana* land. Figure 5.2 consists of a flowchart that depicts a conceptual understanding of the factors influencing health and sickness, according to the older Xhosa women.



Source: Mji.[12]

FIGURE 5.2: The model of health and sickness from this study.

The health problems that are managed by the older women within the home

The current study identified the following three categories of health problems that were managed within the home situation:

- social health problems
- minor health ailments that can be managed at home
- other health problems that require referral outside the home.

The three categories are discussed below.

Social health problems

Globally, there is a problem regarding the implementing of PHC as a strategy in its entirety, especially in low-income countries, where it is most needed.[21,22,25] Instead, selective PHC has been an interim chosen strategy. Such healthcare is mainly what is offered at present by the PC services that are common in low-income countries and in rural areas such as the villages of Gusi. Not implementing PHC to its fullest brings challenges such as the revolving door syndrome, as social health problems that are commonly the cause of disease are left unaddressed.[9] The primary and secondary social health problems that emerged from the findings in this study are outlined in Box 5.2.

In relation to the primary and secondary health problems noted in Box 5.2, the older Xhosa women from *Bomvana* land saw some of the social determinants of health, such as peace in the home and security in the village, as well as the production of food, as their domain and that of the village, which could serve as an asset that could be used in revitalising PHC.[12] The current study suggests that the older Xhosa women on *Bomvana* land, as in the case of Xhosa women in Khayelitsha, should be supported in their roles[12] by the community health forums.[9]

BOX 5.2: Primary and secondary health problems identified in the study.

Primary and secondary health problems

Primary social health problems

- Lack of respect
- Substance abuse
- Alcoholism
- Not planting and ploughing for food
- Poverty in households
- Presence of struggle
- Lack of peace and security
- Lack of motivation
- Unruly children
- Money problems (financial concerns)
- Absence of health
- New diseases
- Not brewing Xhosa beer
- Finding neither sufficient time nor resources for ancestral reverence

Secondary health problems

- Absence of work
- No projects on which people can work
- Absence of clean running water and sanitation
- No electricity
- Lack of money
- Non-receipt of old age pension

Source: Mji[12]

Minor health ailments that can be managed at home

The researcher wishes to propose using the list outlined in Table 5.1 as a starting point in assisting the older Xhosa women to define their scope of practice within the home situation. The aforesaid list itemises the minor health problems identified that could be managed by the older Xhosa women at home.

TABLE 5.1: List of MHAs that could be managed within the home.

Type of minor health ailment	Uhlobo lesigulwana sasekhaya
Facial pimples	*Amaqhakuva obuso*
First stool of an infant	*Ituwa yokuqhala yomntwana*
General cough	*Ukukhohlela okungephi*
Head lice	*Intwala zentloko*
Blocked nose	*Umfinxane*
Mouth blisters	*Amandyunguza omlomo*
Childbirth	*Ukuzala*
First baby rash	*Ishimnca*

Source: Mji.[12]
MHAs, minor health ailments

The above list should be verified and validated by the CNPs in the village health forums, and by the family physicians and GPs. Thereafter, a strategy as to how the MHAs can be managed within the home, with the older Xhosa women playing a key role in this regard, should be developed.

The herbs that are used by the older Xhosa women in managing health problems within the home

Approximately 32 herbs and approaches were mentioned by the older Xhosa women for the management of health problems within their homes. They believed that, for every person born in Gusi, there were herbs that were available for the treatment of illnesses. No attempt has been made to translate the names of the herbs into English, as the researcher did not know what some of them were and what they looked like, as well as their pharmacological effect on the health problems that were mentioned by the older Xhosa women. Listed in Box 5.3 are the herbs used by the older Xhosa women.

The current study suggests that the process of revitalisation of PHC in the area should start with understanding the IHK possessed by the older Xhosa women in managing the health problems in their homes.[3,4] It is important that indigenous herbs that grow in the area are investigated, as the older Xhosa women have an idea that, for

BOX 5.3: List of herbs and approaches used by the older Xhosa women to treat the health problems that they experience within the home.

Umkhamelo; itshungu; inkondlane; umuncane; unogangatshange; umncephe; unohawuzela; mthene; mpinda; umsobo wehlathi; mafumbuka; amanzi olwandle; uthuli lengca; ubuhlungu; isichakathi; isikhikhi; ingxozela; tsasela; impuzi zethanga; ukuthonjiswa; umhlonyane; isindiya-ndiya; sampontshane; imputshi yehashe; umthombothi; impepho; ityholo; amafutha ehagu; umafumbuka; isihawu-hawu; isivumba mpunzi; ixolo lo umnga

Source: Mji.[12]

every illness of a person born in a Gusi village, there is an existing herbal remedy. The above list is probably not comprehensive, as a majority of the elite older Xhosa women were reluctant to mention the herbs that they used and the conditions that they managed.

Medical and other health science students could work initially with the elite older Xhosa women in developing a comprehensive list of herbs for the illnesses that they manage within the home situation. Once they have a comprehensive list, they should work with the pharmacological departments of the University of the Western Cape and UCT to test the herbs pharmacologically and to ascertain the rationale of the older Xhosa women using them for the illnesses that they have mentioned.

Providing training opportunities for medical and health science students in the said areas should assist students in learning about the people of the area, and then about the definition of health and sickness, the health determinants, the diseases that are prevalent in the area and how the people in the area manage the diseases identified. The ultimate goal for students is to assist people to reclaim their highest status, which is to be *Bomvana*. Doing so will assist the students to bridge the gap between the orthodox Western and African sociocultural context.[7] Serpell[6] argues that education should afford students the opportunity to test formal Western theories against the African reality and prepare them for the challenges that they will have to face at work after graduation.

For students to be strong, health professionals within an African context and indigenous communities should provide opportunities for comparing and integrating academic theories and perspectives with indigenous interpretations of experience.

Health problems requiring a referral to an outside person for advice and further management

A total of 31 health ailments were mentioned by FG3 and FG4 as having given rise to critical incidents and as having been referred to an outside person for advice and further management. This list should further be strengthened by including bone fractures and mental illness, as well as any other health ailment that has been omitted by the older Xhosa women. Once validated, a decision needs to be made with regard to the role that the older Xhosa women can play in solving the health problems, and to which point and to whom amongst the healthcare providers in the 18 villages of Gusi should they refer patients.

A proposal for a rural primary healthcare model for the 18 villages of Gusi for the management of health problems within the home

South Africa is promising to re-engineer its health system through a multibillion rand scheme, in which the management, staffing, infrastructure and equipment at public health facilities will be overhauled and a NHI fund set up.[43] Together, and aligned with this, is the re-engineering of PHC that the South African government is promising to its PHC-user citizens.[43] The government acknowledges that insufficient attention has been paid to the implementation of the PHC approach, especially in terms of the lack of focus on the health of populations and the measurement of health indicator outcomes. The re-engineered PHC strategy promises to strengthen the district health system by managing the basics. The basics include an emphasis on

population-based health outcomes, including developing a new strategy for community-based services based on teamwork, including the rolling out of community health workers.[43]

The aforesaid revitalisation of the PHC appears to be giving hope, especially to those in the neglected rural areas,[18,19,20] and could be an important development for some of the challenges that are faced by the older Xhosa women with regard to the management of health problems in their own homes. Caution should, however, be extended to the planners of the PHC revitalisation, as Alma Ata recognised that health improvements are a matter of more than just developing more health services, or of centrally imposed public health solutions.[18,21,22] Alma Ata heralded a shift in power from the providers of health services to the consumers of the health services and the wider community.[28] The wider community approach sees the home as the first entry point to PHC, and the older Xhosa women from the 18 villages of Gusi as first-line practitioners.[8,19] The planning of the revitalisation of PHC needs to be supported with evidence from the study. No work has yet been done that accords the home its rightful place as the first entry point to PHC and which regards the older women as first-line practitioners.[8,19] It is in this regard that the current study suggests the adoption of a rural PHC model to be piloted in the 18 villages of Gusi.

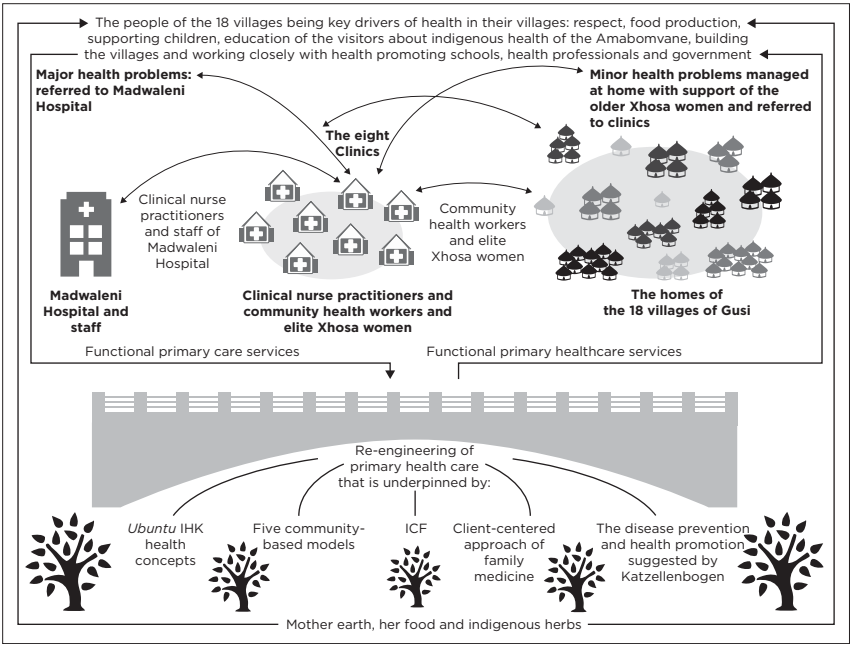
A rural primary healthcare model for the management of health problems in the 18 villages of Gusi

Figure 5.3 is a representation of the cross-sectional component of the rural primary health model envisaged for the 18 villages of Gusi.

A brief description of the functioning of the rural primary healthcare model

The above-mentioned model envisages the following:

- The people of the 18 villages of Gusi are the key drivers of the model.



Source: Mji.[12]
IHK, indigenous health knowledge; ICF, International Classification of Disability and Health.

FIGURE 5.3: A rural primary healthcare model for the management of health problems in the 18 villages of Gusi.

- The community health forums serve as a link between the various stakeholders.
- The 18 villages of Gusi are responsible for the management of MHAs, social determinants of health and the early detection of other health problems.
- The eight clinics supervise MHAs and social determinants of health, and help with the early detection of other health problems, with proper referrals.
- The hospital provides prompt intervention in the case of other health problems and in the monitoring of the smooth running of the suggested rural PHC model.
- Mother Earth, the sea and two rivers supply the people of Gusi with water, food and herbs, including grazing land for the animals.
- The external agents are the government, academics, researchers and international partners.

Concluding statement

Many studies have already challenged the manner in which PHC has been implemented in countries, as it seems to focus on the curative approach to disease and not on prevention and health promotion. It is within this area that the older Xhosa women appear to express the greatest concern for the health of their homes and villages. As was expressed by the older people in the community health forums in Khayelitsha in Cape Town, in terms of the problem of broken family units resulting from the migration of young people to the cities, the older Xhosa women in the Eastern Cape appear also to be struggling with the same problem, which to them has been brought about by the migration of young adults to the cities seeking jobs. The older people who are left behind struggle to keep the home together, as they lack resources to work hard on assisting with the production of food and building the home and village.

In the initial implementation of the current study, the older Xhosa women resisted speaking about the disease aspect of the health problems that they managed within the home. According to them, health problems included social determinants of health, as each disease is linked to a social determinant of health, and the management of health problems includes the management of social determinants of health. To them, it is about the health of the home, and not just about the management of disease. They suggested that healthy homes make healthy villages. For them, the prevention of the development of disease was related to the strengthening of the home. Such thinking is similar to the initial PHC strategy that was devised in Alma Ata in 1978.

The older Xhosa women have outlined three categories of health problems that appear to be blighting the health of their homes and villages. The social determinants of health are being played out within the homes of the 18 villages of Gusi, and are undermining the caring role that has been assigned to the older Xhosa women, who ensure that the health of the home is maintained. Neglecting to keep the home healthy by performing

certain activities and rituals means that the older Xhosa women are dealing with a vast number of health problems, some of which are quite new, and they lack the resources to manage them. To revitalise PHC for health to prevail in the 18 villages of Gusi, a start in, and focus on, the social determinants of health of disease is required.

The current study has shown that improved access to health services does not mean improved health status of the community. Bührmann[37,38,40] explains the importance of linking health not only to an individual but to the whole community, especially in preliterate communities, in which health knowledge is passed on by word of mouth across generations. There is a need to put in place processes for supporting the older Xhosa women, as the present study has shown how vulnerable they are, because of the challenges that they are facing. This will assist in the preservation of the IHK carried by the older Xhosa women.

Now that there is a promise of NHI[43] and the revitalisation of primary health, the current study proposes that the two major national health policies should take cognisance of the IHK utilised by the older Xhosa women, and should develop a clear plan as to how the knowledge can be supported within a healthcare systems approach. A rural health model is proposed by the study as a way of doing this.

Chapter 6

Opting for a veil of secrecy – The silencing of indigenous health service seekers by healthcare providers in *Bomvanaland*

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Introduction

This chapter addresses the evolution of the problem; this is followed by the background and context-related factors; delving deep into the root of the veil of secrecy and the epistemiological silence that the patient had opted to take on health matters when

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using biomedical facilities in their area is explored; impact of the modus operandi between biomedical health providers and their indigenous patients is explained; recommendations are made for all stakeholders; and the chapter concludes with a closing statement.

The evolution of the problem

The methodology of this chapter is based on the methodology discussed in Chapter 4 of this book. The participants include key informants, namely, the chief of the area and his chieftains, 36 older Xhosa women in four focus group discussions (FGDs) and 16 elite older Xhosa women, one being a retired registered nurse who had expertise in conducting in-depth interviews. None of the health professionals from the hospital or the clinics were directly interviewed because of the fact that this was not the focus of the study. The main aim of the current study was to focus on the health problems that are managed by the older Xhosa women in their homes, with special focus on IHK. Drawing from the data analysis design presented in Chapter 4, narrative analysis of key inputs from participants, as well as analysis of narratives that were narrated by participants, was used to extrapolate the challenges faced by participants when visiting the hospital after using indigenous medicine or just trying to understand the management of their conditions during consultation in the hospital.[1]

For health services for the villagers, there are a secondary hospital and eight clinics, of which a majority had opened just recently. Private general practitioners (GPs) could be found in the nearest towns (Elliotdale and Mqanduli), but sometimes patients travelled as far as Umtata and East London to see a popular GP.

What emerged from the FGDs and the in-depth interviews was that there is a generally poor relationship between biomedical healthcare providers of the Madwaleni secondary hospital and the eight surrounding clinics and patients that use these health

services. It is perceived that this is because of poor communication between the service providers and the patients. The situation seems to be worse in three specific areas where data were collected, that is, the two areas closer to Madwaleni Hospital and one furthest from the hospital. The area where situations were better is the area in which the indigenous leaders of the area reside.

There is a level of mistrust between the health professionals and the patients and their relatives who have tried to contain the health situation 'on the quiet', using whatever home remedies, including indigenous herbs, that are available at home before visiting the hospital or the clinic. This has resulted in them being chastised by health professionals for attempting to use any available medication when their relatives are sick, especially at night, as some households are located quite far from the hospital. This type of approach by health professionals creates mistrust, with health professionals perceiving the patient as having used some form of 'voodoo *muthi*' prior to coming to the health centre. Because of this situation, people using these services opt for a veil of secrecy as they feel stigmatised, chastised and ashamed of the IHK they have used prior to coming to the biomedical health centre. In some way, they feel silenced by the biomedical health providers who appear to be the knowledge holders on the issues of biomedicine and the power it exudes in the area on matters related to health. This makes it appear that there is a lack of space and time to accommodate other approaches to healthcare, including IHK, which is still widely practised by this community.

Background and context-related factors

Madwaleni boasts of a variety of indigenous health healers situated within the folk arena of Kleinman's[2] model. The older Xhosa women and the elite older Xhosa women are restricted to their homes and reside within the popular arena of Kleinman's model.

They use indigenous herbs and follow indigenous health belief systems. It appears that the relationships between these indigenous health providers and biomedical health providers is quite thorny. The challenges that the older people were complaining about when they were attempting to access the PHC services were mainly regarding the hospital. They stated that the clinics were quite new and though they are supposed to first use the clinics before going to the secondary hospital, most of the time they overlook the clinics and go straight to the hospital. There are many reasons that influence the older Xhosa women in resorting to using IHK at home.

In the 18 villages that were covered by the study, it appears that distances had a direct impact on the health-seeking behaviour of patients who sought help from the PHC services. The hospital is almost central to the 18 villages, and the two rivers and their tributaries, as well as the sea (the Xhora and Mbhashe rivers – see Figure 4.1). Accessing the hospital in the rainy season (i.e. summer) is a problem for some of the villages, as sometimes the two rivers are filled to their maximum capacity. The findings from the four focus group discussions (FGDs) are similar to those in relation to the indigenous communities in Bolivia and the Amazon, where persons farther from the health facility who tried to manage the health problem within the home, using whatever means they had available, including IHK, were chastised by health providers.[3] Those that were further away from the hospital also appeared to be managing health problems that were quite complex, and reporting them quite late, when complications had already set in. When they struggle to contain the illness using IHK or they notice that a person is not improving despite having visited an indigenous healer, they resort to taking their relatives to biomedical health services. When the relatives bring the person who has used IHK, a communication breakdown between the patients and their relatives, on the one side, and the health professionals at the hospital, on the other, occurs.

The older Xhosa women complained that they could not be honest about the IHK that they had utilised before bringing their relatives to the health service, as they were chastised by health professionals for having worsened the condition of the patient. The health professionals, who were predominantly nurses, with a majority of them being Xhosa and from the study area, saw the *AmaBomvana* people as difficult to change and educate regarding the management of health problems using health services. They also believed that they worsened the condition of their already ill relatives, as they lacked a biomedical understanding, firstly, of the pathophysiology of the disease and, secondly, of how the disease is managed from a biomedicinal perspective. It also appeared that the health professionals were insensitive to the accessibility issues that their patients experienced when trying to access health services, especially at night.[4,5]

It appeared there was a general lack of trust between the patients and their relatives on the one side, and the health professionals in the area on the other side. The former gave indigenous medication to their relatives without informing the hospital, telling their relatives to hide the fact that they had taken the indigenous medication. It appeared that, in the 18 villages, the promoters of biomedicine and IHK were acting against each other, with each side claiming supremacy. The situation was unhealthy, for both the IHK utilised by the older Xhosa women and for the biomedical practice, as well as for the sick patients and for the inhabitants of the area. As patients and their relatives opted to keep quiet and to practise their IHK silently in the dark, this made them vulnerable to both biomedical and indigenous knowledge charlatans, as will later be revealed in this chapter. This communication problem between the health professionals and their patients also seems to be linked to communication challenges amongst the staff of the health providers of this area, as will be discussed subsequently.

Challenges of hospital doctors who cannot communicate with their patients in Xhosa

The doctors at the time of collecting data for this study at Madwaleni Hospital were mainly white doctors who could not speak Xhosa.[6] The issue of health and illness requires the doctor to understand the historical background of the patient's illness directly from the patient.[7,8] The doctors at the hospital used nurses as interpreters for their Xhosa-speaking patients. It is believed that much valuable information regarding the patient's illness was lost during interpretation sessions.[5,9]

The practice was open to a number of misuses with regard to the doctor and the patient by the nurses who acted as interpreters for them. The Xhosa patient and the English-speaking doctor were vulnerable, as they could neither communicate with each other nor understand one another with regard to the patient's illness. The person who held the power of communication was the nurse. Malcolm[10] explains the pitfalls of poor communication between patients and doctors in medical practice. His concern is further highlighted by De Villiers[11] and Blitz,[12] who also elaborate on the importance of communication in a conducive patient–doctor relationship. The nurse who has been drawn in to interpret does not see doing so as her/his role. It is assumed that the doctors cannot have the same understanding of the aetiology of the illness as the patient explaining his/her case does, because the nurses summarise what is told by the patient about his/her illness, omitting points that he or she considers to be unimportant for the doctor. Some of the nurses end up avoiding the responsibility of translating for the doctor and the patient because she/he seems not to perceive this as his/her role. This results in everybody sitting on the fence, with the patients and their relatives incurring the displeasure of the nurses and doctors once the latter are informed that the patient has used IHK before coming to the hospital. As a majority of the patients do not have formal education, minimal information is absorbed about the aetiology of their illness and the explanation given by the

doctor in this regard, including the suggested management strategy. This information too is communicated quickly in a staggered fashion (similar to how the doctor was informed about the patient's illness), which is very confusing to the patient who is used to listening to stories in his home and village about the root cause of the problem and how they could be sorted out. This results in patients who are reluctant to talk about their illness, including the medication they used before coming to the health centre.

Delving deep into the root of the veil of secrecy and the epistemiological silence

When delving deeply into the root of the veil of secrecy and the epistemiological silence that the patient had opted to take on health matters when using biomedical facilities in their area, Mji[1] suggests that this might come from the fact that there is a general structural, institutional problem of stigmatising, chastising and making indigenous health users feel ashamed of the IHK that they have used prior to coming to the biomedical health care centre. This results in them opting for a veil of secrecy, as they feel hesitant in talking and explaining the indigenous ministrations they have applied to their relatives at home to health care professionals, including the medications they have used prior to coming to the health facility. There is also a general approach of not listening and supporting patients by the nurses who act as the go-betweens for the doctor and the *Bomvana* patient and their relatives. These nurses, though they hold the power of communication with the indigenous patients as the doctors can only communicate in English, appear to be disinterested in supporting their indigenous patients. This disinterest by the nurses in explaining to the doctors comprehensively about the patient's sickness, including the fear of being chastised for having used indigenous medication, make the person and their relatives opt for a veil of secrecy as they

feel silenced in explaining comprehensively about their sickness and its aetiology. The researcher senses that this silence seems to appear from a deeper epistemic devaluing that has happened on the side of the person and their relatives long before they visited the hospital.

When describing the community of Madwaleni in Chapter 4, it was noted that education had managed to divide and split the *Bomvana* into two groups, illiterate people and school people, with the school people following modern knowledge, including on health matters, while indigenous people follow the indigenous knowledge that is linked to the past and has been overshadowed by modern science, which has sidelined indigenous knowledge systems.[13]

The *Bomvana* people see the area of health and sickness as being linked to relationships. These relationships need to be balanced for one to feel well. Broken relationships cause ill-health and for one to fully reclaim ones' health from a sick condition, one has to reconnect with ones' ancestors and ask for mediation from them in assisting to rebalance relationships and further protect one from ill-health. B*ü*hrmann[14] explains the relationship of the Xhosa people with God by highlighting that although there is the misconception that the Xhosa people worship their ancestors, it is not true. The Xhosa people revere their ancestors, who are seen as the link between God and the living – they are seen as intermediaries between God and those who are still alive.[6,7,8,15,16,17,18,19] This was the case with the older Xhosa women from Bomvanaland – they showed ancestral reverence, and their ancestral connection assisted them when their health strategies were not helping, as, usually, the ancestors, who might have been the previous grandparents who had assisted in validating her knowledge, came in the form of a dream, instructing them regarding where they might find the correct herb for a sick person. To them, to have ancestors on their side was good for the health of the home, and helped to facilitate the maintenance of the health of the home, as they felt supported and guided by

their ancestors in promoting the health of the home.[6,17] They further challenged the Christian orthodoxy regarding the positioning of Christ and the angels, and challenged whether these beings were in any way different from those they, in their world, have classified as ancestors.

The above might also be another source of mistrust regarding the hospital that was built by missionaries who brought Christianity to those areas. The ministers, who were mainly practising their belief from an orthodox perspective, nullified and ridiculed the ancestral beliefs held by the *AmaBomvana* people.[6] According to the *Bomvana*, Christianity not only deprived them of meaningful contact with their ancestors but also deprived them of their relationship with God, as the new religion that had brought modern health services to Bomvanaland failed to recognise the *Bomvana* people's use of ancestral reverence as a way of connecting with God.[15] Without ancestors, there was no link with God. It appeared that the participants believed in the same God that the ministers from the Dutch Reformed Church believed in, with the difference being in how to link with the God of their faith. For the *Bomvana*, such linkage was via the ancestors, whereas, for the traditional Christian believer, the linkage initially was to be direct and later via Christ.[15]

The *Bomvana* chief delved deeply into this matter of foreign entries having ignored their prior knowledge and sees this as having undermined their health indicators. This perception of the chief, though put more crisply with regard to its sequel, is not different from perceptions of other indigenous scholars who point to the impact of coloniality and power.[15,16,17,18,19] They warn that there is a difference between colonialism and coloniality, whereby coloniality is about entanglement of differential power through which the colonised is subjugated and hands over the power of thought, speech and action, accepting being devalued, and is devowed by the one holding power in ways of thinking, living and doing.[14] This devowed subjugation process opens colonial wounds and creates epistemic silence, as the indigenous

knowledge holder, firstly, feels upset for having allowed herself/himself to be devowed and subjugated, and, secondly, embarrassed as the white mirror he or she is given to measure herself/himself against looks so different from the indigenous vision and internal mirror he holds about himself and his knowledge.[14] This is followed by shifting the blame as one feels vindicated for holding the knowledge back and not standing up for the knowledge they hold. Ultimately, a deep internal hatred of the self starts to emerge with some buying bleaching creams to make their skins lighter, even if these creams damage their skins.

In the earlier chapters, the elite older Xhosa women have already mentioned how the education system of their children has managed to cause a rift between them and their children; the more their children progressed with the present schooling system, the more they felt alienated from them. Indigenous scholars[14] warn that once a child has schooling up to secondary level, the decolonial script would have achieved its objective of colonising that child with regard to space, time, including knowledge and emotional aspects. The elite older women classify this as slavery as they maintain that their children who are educated – even if they move to urban areas where the foundation of this new education and civilisation seem to have drawn and embedded its roots – will never be equal to their urban counterparts whose roots are indigenously planted in these areas. This state resembles that of the patients at Madwaleni Hospital who feel chastised and embarrassed by health professionals in the secondary hospital – this is a situation similar to the children of the elite older Xhosa women who move to urban areas and are misfits in these areas. They too are being silenced by modernity in that they seem to lack roots for that civilisation.

As the tussle between health professionals and their indigenous patients continues, what is becoming clear is that slowly the indigenous knowledge holders are losing the knowledge they

hold for the management of health problems within the home situation, while on the other side they are not understanding biomedical healthcare management strategies, as a majority of the users of these health services have not received formal education and the relationship between them and the health institution is not conducive to absorbing new information. This leaves them open to charlatans both from the biomedical fraternity and IHK sector, as the two case studies discussed further will demonstrate.

Impact of the modus operandi between biomedical health providers and their indigenous patients

As a means of demonstrating the poor relationship between indigenous patients and their biomedical counterparts, I will present two cases not directly taken from Madwaleni Hospital, but from a similar setting outside this area, to demonstrate the vulnerability of indigenous patients:

Case study 1: The traditional healer charlatan antics

This story was narrated by one of the elite older Xhosa women, a retired registered nurse who had previously worked in the operating theatre of a district hospital outside the study area. Her hospital was close to the N2, which is one of the main roads starting from Cape Town, passing through Port Elizabeth, East London, Umtata and up to Durban, and passing through all the small towns and villages situated along this major national road. In her hospital, they admitted many victims of car accidents. Some of the traditional healers – and I classify these healers as traditional healers as they seem to be stuck within a certain ideology and mentality, whereas indigenous healers are continuously reflecting on their scope of practise

and changing it– on hearing that she was working in a theatre, begged her to collect and give them any bits of flesh being cut from a white patient during surgery to use in the making of strong medicine. One can, firstly, see how far the colonial factor has affected these traditional healers' minds and, secondly, the plight of their patients as their medication will certainly contain some deposits of a white man's flesh, which is of major concern.

Case study 2: The biomedical nurse who wants to have her cake and eat it too

This again is a hospital setting outside the study setting, referred to here as a means of highlighting how poor communication can also make patients vulnerable to biomedical charlatans.

This is a situation in which the doctor cannot speak Xhosa, and nurses act as interpreters. The patient explains his condition to the nurse – the nurse quickly gives a short explanation to the doctor, though the patient had narrated a long story about his illness. The doctor had to step out in the middle of the consultation. While the doctor was gone, the nurse turned to the patient and asked him:

> Why have you come here, do you think there is any help you are going to get here, do you think they can recognise what is your struggle and sickness? Meet me at lunch time at the gate and I will assist you. (76, female, Retired Nursing practitioner)

From what we understand, this type of assistance comes at a price.

There were stories in this area about nurses practising both traditional medicine and biomedical care. The question that needs to be asked is: As health professionals who practise both biomedical healthcare and IHK care, why are they not trying to work with both these groups to forge a better relationship

between these two health providers and build a bridge between the healthcare services and the community, instead of taking advantage of the patients? Could it be possible that they too are struggling with the same feelings of embarrassment and being belittled as their indigenous patients are? It appears that it is not only the patients who have opted for a veil of secrecy and are being silenced by modern knowledge. The older Xhosa women from the fourth FGD who were angry about their IHK being overlooked by the biomedical health professionals, when asked by the researcher what they were going to do, suggested that their children, the educated ones, will assist them in spreading their knowledge and bringing it out in the open. How can this happen when the nurses, 'the educated ones', a majority of whom are from Madwaleni, are chastising the patients who consult at the hospital after using IHK, while some of them are secretly practicing IHK with the very patients they are chastising. It appears that these nurses from this area, though the biomedical institution is in their area of work, handle both the doctors and patients they serve with some form of contempt. The question that needs to be asked is: Is this behaviour really directed towards doctors and patients or towards themselves, who, though they are the educated ones, are failing to take the role that has been given to them by the older Xhosa women? – their children, the educated ones, will carry forward their IHK. Instead, on the quiet, these nurses are taking the indigenous health patient away from the biomedical healthcare to manage them on their own. In other places and times, it is also revealed that these biomedical indigenous charlatans, when the patients they have directed away from biomedical healthcare begin to manifest complications, return these patients to the biomedical healthcare facility. The question that needs to be asked is: what is the difference between these biomedical indigenous knowledge charlatans and the relatives of the patients who, at home on the quiet, have utilised IHK? It appears that the veil of secrecy needs to be lifted for ALL, for the sake of the patient.

Exposure of indigenous patients to both indigenous health and biomedical charlatans

These two case studies expose the vulnerability of indigenous patients to health charlatans, with the second case study being of greater concern. The first case study illuminates how the colonial mind has permeated even those that are classified as indigenous healers, and how this further exposes patients to belief systems that worsen their illness. As suggested by the chief of *Bomvana*, the loss of ones' identity appears to be influencing even those who are highly regarded in their villages, such as the indigenous healers – they too want to use the white mirror to strengthen their healing powers.[14] The question that needs to be asked is: are they prepared to take the entire white picture in the mirror, including its civilisation, or do they select only what pleases them so that they can convince their patients of the strength of their medicines?

The second case study is more concerning, again raising a lot of questions with regard to ethics of care,[20] accountability and the rights of the patient. It also demonstrates the vulnerability of health systems that are hierarchical in their approach, and that they could be quietly eroded even without being aware of this erosion. The above two case studies, though not based at Madwaleni, present situations that are similar to the challenges that are faced by the Madwaleni health providers and their indigenous patients. The relationship that exists between biomedical care and indigenous healers in this area does require some attention. The prevailing poor communication issues are threatening to undermine the successful management of health problems in the 18 villages of Gusi, by not providing the IHK practitioners with a platform for discussion, interrogation and consideration of the good attributes of IHK, which should be encouraged as part of the management strategies used by the Gusi villagers. While the older Xhosa women were losing IHK at quite a fast rate, it appeared that the rate of learning about

biomedicine was quite slow – as has already been shown, the low assimilation levels of biomedicine and the fast rate of losing IHK that the older Xhosa women from FG 1 and FG2 had shown, meant a double loss of health resources for the rural community.

Loss of indigenous health knowledge, resulting in finger-pointing and blaming the other

As IHK was conveyed by word of mouth amongst the older people, to question them was seen as disrespectful.[21,22] As the older Xhosa women from FG1, which was close to the hospital, were gradually losing their IHK, this increasingly became more of a problem, because the knowledge was not replaced with a new understanding regarding the new approaches of biomedical care. The above presents an element of helplessness and passivity regarding either resorting to biomedical care or remembering and applying IHK when health problems emerge at home. It also means that the FG1 participants' gradual integration of biomedical care into the home was occurring quite slowly, as they lacked the tools (i.e. an understanding of English and interpretation) to integrate it into their existing knowledge base.[23]

The impact of the loss of IHK results in opting to bring all illnesses, even including those that are classified as MHAs, to the hospital. It appeared to the group in question that they were gradually forgetting how to manage minor health problems at home. In contrast, they were also not learning, with regard to biomedical care, how to manage health problems at home, as they were not questioning how the doctors and nurses managed the health problems, and the health professionals involved did not find it necessary to explain to patients how their condition was being managed.

Over and above such a situation, the FG1 participants blamed the hospital for bringing all illnesses into the area, while they continued to be the consumers of the services provided by the

healthcare institution. This situation was problematic, as everyone appeared to be sitting on the fence, with no one being prepared to address the situation as such.[23] The existing situation undermined the growth and development in the management of health problems for both sides concerned, with the losers mainly being the older Xhosa women. Health professionals are fairly mobile,[24] so, if they are unhappy about the status of health services at the local hospital, they could move on to other functioning health services.[12] Hence, in terms of the said modus operandi, the hospital management should ensure that patients find a conducive environment that encourages openness and working together with the patient and their relatives at the hospital. The most important skill that they will need to utilise in doing so will be that of listening to the patient with regard to the approaches that they use for managing their relatives when they are sick at home. The health professionals, in contrast, were responsible for transferring health knowledge and skills to their patients about the first help that they could give to their patients within the home situation, and about when they should bring them to the health service.[25,26]

Finger-pointing and resolving to go back home where knowledge was lost

Focus Group 2 started by acknowledging that the first help came from home. It was difficult for them to explain what the first help was, but it appeared to amount to taking patients back when the home was the only available healthcare provider. It appeared that they did not take their health seriously, but they rather traded their knowledge of health for their awareness of God. It is important to note that different concepts of health, education and religion were introduced by Dutch ministers of religion to the *AmaBomvana* people.[6] It appears that the group was lamenting the fact that they had neglected health issues and had allowed

ministers of religion to take over both their spiritual and health needs, as they did not develop their IHK within the home, which many scholars classified as traditional knowledge.[27,28] Health experts from the domain are classified as traditional healers, although the indigenous people of the world challenge the notion, explaining that indigenous knowledge is always developing and changing.[27,28] Instead, they allowed the Dutch ministers of religion to take care of their health needs and develop hospitals. It was highlighted in the literature review that the promotion of IHK was hindered by religious groups and colonisation, as the need to conform to educational expectations and norms of modern civilisation became unavoidable.[6,27,28] It appears that the participants of FG2 struggled to balance the new incoming knowledge of the coloniser with their own interests in managing their health at home. The consequence of this was a combination of responses that, on the one hand, was about lamenting about what they had done in allowing their health to be managed and processed by outsiders. They felt that they had traded their health for Christianity, whereby, according to the *Bomvana*, health and religion were combined. By ignoring the fact that they already had a God to whom they related through ancestral reverence, they had angered the ancestors,[6,7,8] resulting in their ill-health. Their neglect in allowing their health to be managed by other people, and not within the home, where ancestral reverence was meant to be uppermost, had deepened their plight, thus causing more ill-health in the home. Hence, in the prevailing situation, the best approach was to return home, where ill-health started and wellness could be reclaimed, including the reclaiming of *UbuBomvana*, as has already been explained in the previous chapter, means to *be Bomvana*. It is believed that this will result in them facing the healthcare providers from a point of authority, as they will have reclaimed their identity and re-cultivated the knowledge of the management of health problems that was held by the older Xhosa women, and this would assist in the reviving of their civilisations as civilised warriors.[6,7,8,15,16,17,18,19]

Recommendations

The communication problems between doctors and patients and nurses in Madwaleni Hospital was of great concern to the researcher. It is within this concern that the researcher perceives that there is a need for properly trained interpreters who are bilingually fluent and have some understanding of both biomedical healthcare and IHK. Sign language interpretation should also be included in their training, in order to enable them to interpret for deaf patients. The current study should be a motivation for all the doctors and any other health professional who cannot speak Xhosa, and who are not from the 18 villages of Gusi, to learn Xhosa before they start work at the hospital and clinics that are situated in the area. Such training should include coverage of cultural concepts, including how to be *Bomvana*, as has already been shown by the current study that the *Bomvana*, like the Maori people of New Zealand, feel healthy when they are aligned with their cultural practices.[6,29]

As the majority of the nurses are usually from one or other of the 18 Gusi villages, they have some understanding of the prevailing culture of the area and of the IHK possessed by the older Xhosa women, because they were once the grandchildren of such grandmothers. One of the CNPs from the area had shared a concern that the older Xhosa women were going to lose their knowledge of how to manage minor health problems within the home setting. What she overlooked was their approach to the older Xhosa women. Whenever they had tried a home remedy and the patient showed some complications, they were chastised for doing so. The current researcher further suggests that the nurses should develop a social contract, in terms of which they should use their understanding of indigenous health practices as a bridge to enhance the doctors' understanding of the indigenous interpretation of the patient's illness, including what the patient might have used at home to manage his/her illness. Nurses must also be encouraged to give a proper explanation to the patient of the doctor's response and interpretation of the patient's illness,

as well as of the management strategies that the doctor is planning to use to manage the patient's illness.[30] Only when this happens, can the doctors start acknowledging the importance of, and learning about, IHK. The patients could then also learn about biomedicine, and an exchange of skills and competencies could start from an informed position.

It appears that those who were close to the healthcare facility appeared to bring all their health problems to the healthcare facility, even those that could be classified as minor,[21,26] and by doing so they were rapidly losing the IHK for the management of health problems at home. Although the summer months in this area present the problem of swollen rivers that prevent patients from accessing health services, in contrast, the elite older Xhosa women, in in-depth interviews, saw summers as good, as they explained that the wet season brought moisture to areas that were rich in herbs, as well as to the forest. Unfortunately, the herbal resources were far from FG1 and FG2. The hospital was built in a rocky area, hence its name: Madwaleni Hospital (*idwala* in Xhosa means 'a sheet of rock'). It has already been explained that the older Xhosa women from FG1 and FG2 maintained that they did not use herbs and IHK for managing health problems within the home. This further supported the argument made by the older Xhosa women from Khayelitsha that the lack of the availability of herbs might also have a direct impact on health-seeking behaviour.[3,21,31] The areas that the elite older Xhosa women said were rich in herbs require investigation. Once the herbs have been tested for their medicinal properties, they should be made readily available to the older Xhosa women who stay at some distance from the areas. It is believed that the older Xhosa women have not forgotten about the nature and the use of the herbs. Three of the elite older Xhosa women from FG1 and FG2 still sent their grandchildren to walk in the damp areas to collect herbs.

The starting point should be the revitalisation of PHC, using the patient-centred approach of family medicine. To listen to the patient and to understand the patient's context, according to

family medicine practitioners, is the first step for re-establishing the health of the patient.[3,32] Such thinking by the healthcare providers of the area, that the older Xhosa women should not manage their sick relatives at home contradicts the findings of many researchers who see the implementation of PHC services as not being comprehensive, with some areas existing totally without coverage, and with certain areas having services, but not holistic ones. In this revitalisation of PHC services, easily available transport for taking a sick person to the healthcare service, especially at night, or the implementation of mobile healthcare services should be included. The proposed revitalisation of PHC[32] and of NHI[33] will have to take all such matters into consideration during the overhaul of PHC in rural areas.

Concluding statement

The communication problems exposed in this chapter regarding the health services of the study setting evokes a lot of concern. It appears that there is no one ready to take responsibility for these challenges. Indigenous health knowledge is still struggling with many issues, including issues related to being acknowledged and recognised as a part of the healthcare modality. The communication problems that are blighting the healthcare services in this area, and their indigenous patients, seem to be larger than the persons who have used IHK and might need space for a deeper exploration using research methodologies, such as participatory action research, so that as you are investigating the problem you are also putting in place strategies to deal with the problem. In places like Khayelitsha, strategies such as developing community health forums have been put in place as a bridge between the health services and the community and seem to play a major role in mitigating communication challenges that were similar to those of Madwaleni.

Chapter 7

The heavy price paid by the *Bomvana* in questioning the Western modernity script of civilisation

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> Can religion, education and biomedicine undermine the health indicators of a rural community? (86, male chief of the Bomvane)

These were the lamentations of an indigenous chief of the *AmaBomvana* about the health status of his village (in honour of the late Chief Vuyisile Qothongo and Chieftain Tinky-Penny of the *AmaBomvana*: A Mhlekazi!!).

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Introduction

This chapter highlights how hegemonic knowledge of the West, including their colonial powers, uses a lens of imposition and a tendency of choosing to be arbiters of the existing indigenous knowledge systems.[1,2,3,4] The chief of the *AmaBomvana* laments that new modern systems of delivering health, religion and education that have entered their calm existence have overlooked their daily cultural practices. This chief believes that the enforcement of these three aspects by external agents that assumed that their communities were blank slates, resulted in a fractured, ill community struggling with their beingness, becoming (which is part of creativity) and diseases. This chapter intends to outline the challenges that were faced by this indigenous rural community as a result of external invasion that refused to acknowledge indigenous peoples and their way of life. It will further motivate, particularly for biomedical health systems, the understanding that health is life, and to ignore people's way of life is not conducive for progressive health systems that are underpinned by respect for cultural differences and human dignity.[5,6,7]

Connecting with the lamentations of the chief of the *Bomvana*

As mentioned in Chapter 6, the focus of the research that underpins this book was not related to the chief of the *AmaBovane* but to the older Xhosa women who are the carriers of IHK.[7] The researchers were guided by their participants in throwing light on and clarifying the research question. The preview of this book already attests to how, in addressing the research question, as it continued to unfold, participants were assisting the researcher in understanding that the health problems that are blighting *Bomvana* within their home situation, and how these are managed or not, need to come from *Bomvana*, and not from the researcher trained from a Western perspective.[3,4] In opening this chapter,

I am going to start this session by presenting the conversation I had with the chief and his chieftain of the *Bomvana*. I have explained in Chapter 6 that my intention was not for the chief to participate in the research; nevertheless, his contribution seemed to further expand and deepen my understanding of the health challenges faced by the *Bomvana*. Below is a presentation from the conversation with the chief and the chieftain, with minor alterations here and there:

> I have gratitude from the bottom of my heart that you have come to our villages to seek for this knowledge. This place is the place of the *Mbovane* tribe. We are people of traditions and rituals. These traditions were first undermined by religion and education and how health was practiced amongst our people. We were given bad education that undermined our traditions. That is why we are in this mix up and confusion. Cattle are something important to our people. In 1740 Qayiya disappeared and came back via the ocean with two cows. These cows were our ancestors. They brought prosperity to the Xhosa people. We have lost all these traditions and the appearance of Qayiya with cows was only celebrated once. During this time women are not allowed to come to these celebrations, only girls, we are not sure of the reason. We never asked why. We would be seen otherwise. Qayiya died here in Guse. For a newly married woman to the household there were traditions. During the reign of King Zwelibanzi (meaning 'the world is wide'), one of the ministers that trained in a far world brought religion and education and medical education through the Presbyterian Church. (86, male, chief of Bomvane)

The building of this church is encased in the same yard that the hospital is encased. It was only in 1956, when Madwaleni Hospital was built, that women gave birth in a hospital. While the women were giving birth at home, the men would be in the kraal waiting (*I also see this waiting in hospital corridors; maybe the home was seen as a hospital those days*), and once the child was born, one of the women assisting with the birth would bring the news. If it was a girl, these men would turn their heads away with disappointment; if it was a boy, this was received with jubilation and celebration. (*The AmaBomvana are a strongly patriarchal society.*) The women after birth would be sheltered for 8 days, and on the 8th day there would be a celebration for the newborn.

Beyond the home, there was the *amagqirha* [those that diagnose] and the *amaxhwele* [medicine man]. (*This affirms Mji's*[7] *assertion that the amagqirha fall within Kleinman's folk arena.*) So when you are ill and cannot be assisted at home, you go to the *igqirha* who tells what is wrong and then the *ixhwele* prescribes the appropriate medication. As the child grows, these rituals are continued. Once the young boy reaches adolescence, he has to be circumcised. There are certain pre-circumcision rituals (*ukungcamliswa*) (*nokunyatheliswa*), whereby the boy must bite into a mielie cob smeared with a bitter medicine (*umthathi* – a very bitter medicine that brings a sense of purpose and has medicinal components). (*One also notices that the chief does not include the girl child in these rituals of entering adulthood, although the* intonjane *initiates the girls into adulthood*). This ritual symbolises that the young man must produce his own crop for the sustenance of his family, and the bitterness of *umthathi* also symbolises that it will not be easy – endurance and patience are required.

Then Chief Xotongo lamented that:

> We are going to experience a time where our sons will have no mielie cob to bite as there will be none as there will be no body to plant mielies as young people are busy drinking beer in taverns. Also our methods of ploughing using cattle are undermined by the technology of tractors that we do not have resources to maintain once broken [*new emerging studies in places such as Australia are highlighting the importance of indigenous way of ploughing for sustainable development*]. (86, male, chief of the Bomvane)

> The previous President of the Old Transkei tried to introduce these tractors in 1994. We are in great danger. People in the village are selling liquor – beer. They do not sleep; these taverns are open for 24 hours. If young people do not sleep, when you need to go to the fields to plough at 4 AM where will you get the energy. People from the top come hear saying they have licenses from government to run taverns. This can be money to others; it is a health hazard for our children. When you are drunk you cannot think, this could be the reason why we cannot even control this HIV. Just imagine 9- to 11-year-old boys drinking. This country cannot go anywhere. We have allowed the government to deal with issues, whereas the government

> is the people. Taverns in – health and agriculture down. You cannot even punish your child; government intervenes and says it is child abuse. I do not understand. Even the Bible says a child must respect his/her parents. (86, male, chief of Bomvane)

At this point, Chieftain Tinky-Penny Ndala took over the discussion. *Umhlekazi kudala ethetha* [the chief has been talking for a long time].

(This is an accepted approach in the chief's kraal, whereby the chieftains also give their input[s] to the chief's contribution, and to enhance the contribution in case the chief has forgotten something.)

'I am going to open up, you will select what is necessary in what I am going to say' (he then took off his hat). I asked him why he is taking off his hat, and he said, 'I am the child of Tipheni; I took off my hat when I am speaking [*sic*] to respectable people' (the reader here is introduced to the cultural aspect of *ukuhlonipha* [respect for others] of the Bomvana):

> Liquor kills nations; I have seen liquor delivered to people. Xhosa beer is made by the people when there is a ritual and a need to celebrate or connect with the ancestor. The chief also used to assist with the aggressiveness of the youth. Now those powers have been taken from the chief. This is painful and it is at the core of people's existence – health. I asked Madwaleni Hospital to allow me to come and pray for the dying people but the doctors said this was unnecessary. Our traditions were developed for our culture and wisdom. (80, male, Chieftain Tinky-Penny)

> Ministers of Religion and Schools, these two institutions have destroyed peoples' cultures. They have confused a black person. We are going back and nothing is going to help. We can only survive only if we adopt *a backward and forward movement.* I asked, what this backward and forward movement is. He explained that we need to be allowed by those that carry the modern culture to go back and retrieve the good things about our culture and move forward with those and continue like that; whenever we encounter a new modern concept we need to go back. Each modern concept must be underpinned by good old ideology. Each household must choose between religion and traditions. A household that practices none, that household is in great danger (*kuphandle kuwo*). That household

> is in a very poor shape. Health issues are very difficult. Black people when doing rituals speak to ancestors. They do not speak to God. Church happens from inside the kraal/parameter of your household; the kraal is where you keep your cattle and this is your religion. (80, male, Chieftain Tinky-Penny)

Christianity caused it all, and now it has become a messy situation. We are holding on to our traditions while, on the other hand, the ministers of religion who have not been selected by God are preaching about hell. You are never taught to preach – you are given the power by the spirits. A minister is supposed to be a prophet.

'Aah Vuyisile, what will save your religion?' (80, male, Chieftain Tinky-Penny). Here, the chieftain is again reminding the chief of the danger at hand – it is presumed that the religion of the chief is drawn from the indigenous knowledge systems. If one looks at this kraal and the interaction of the chief with his chieftains – to the researcher – this looks similar to Caesar's Kraal in the Roman Empire, with the soothsayer warning Caesar of the ides of March:

> God will save a few, so that men do not get destroyed. God has brought HIV to sort this out. Abstain is the answer. I abstained from food for a while when I was in trouble. You must pray to be saved, that is why I abstained. (80, male, Chieftain Tinky-Penny)

Chief Vuyisile entered the discussion and said that he wants to thank Babu Ntiphela for his contribution. He further expanded that:

> Everybody comes with their own perspective on how they interpret things. The Bible was introduced badly by white people. Ministers quoted from the Bible and made the Bible God whereas God is hidden – nobody knows who God is. 'There are many interpretations of who God is but the Bible puts one interpretation'. (86, male, chief of Bomvane)

From the above transcript, one can see that the *Bomvana* had their own systems. One can also pick up the concern of these elderly indigenous knowledge scholars about the plight of their villages. Chief Vuyisile classifies this as a mix and confusion, while Chieftain Tinky-Penny described it as a messy situation. Both of them are pointing to how this situation had impacted negatively

on their health status, including the lack of the postcolonial government to give direction; instead, it is seen as exacerbating the situation. One cannot afford to overlook and not see what is happening in *Bomvanaland* – already there are strong signs in the chief's communication that the girl child was seen through another lens, which was not very appreciative of the newborn.[8,9] As the community continues to think about challenges, they also need to reflect on aspects that they too are responsible for in this conundrum. Spaces where women are not given a voice rarely thrive. The mutual respect that is shown by these two scholars is an important example of how indigenous people used to handle their matters. Respect was uppermost. The people of this area attest to the fact that their grandfathers were civilised, proud warriors. When presenting the *AmaBomvana* to anthropology students in an international gathering, one student asked, '[i]f *Bomvana* saw themselves as civilised proud warriors of that time, how do they place themselves within the postmodern era?' (Student, undisclosed gender, date unknown). One of the elite older Xhosa women maintained that their children, the educated ones, will take their knowledge into the future. The challenge with this statement is related to the fact that IHK is encased in the heads of older generations – maybe, the solution depends on how we include these knowledge holders in the present education system for future generations.

Background and context-related issues

Who are the *AmaBomvana*?

In an international context, the term 'indigenous' is understood mainly by the Western knowledge holders (as indigenous knowledge holders have no need to categorise themselves) as being similar or synonymous with 'traditional', 'Aboriginal', 'vernacular', 'African', 'black' and 'native American'.[10] The phrase 'indigenous' people refers to a specific group of people occupying a certain geographic area for many generations.

They possess, practice and protect a total sum of knowledge and skills constitutive of their meaning, belief systems, livelihood constructions and expression that distinguish them from other groups.[11,12,13]

In principle, the African Indigenous Knowledge Systems (AIKS) are 'informed by and relate to all domains of life and the environment'.[12] However, the contemporary politics of indigeneity and identity are such that people have multiple and overlapping identities shaped by the present political and economic dynamics and their manifestation on the sociocultural context.[14]

All these practices and skills are performed within a cultural context and involve rituals, some of which include songs, dances and fashion,[14] that are in harmony with nature. Unlike the mechanistic conception of reality (as first entertained by Sir Francis Bacon), which advocates a vicious approach to nature,[5,10] AIKS emphasise the importance of a harmonious 'interrelationship and interdependence of all phenomena',[11] be it biological, physical, social, cultural or spiritual. Indeed, despite the fact that AIKS are contextually and culturally bound, all indigenous communities across the globe share in common their respect for all forms of life, contrary to the modern separation of humans from their environment.[11] In response to the question as to why then is indigenous knowledge system (IKS) often called a system, Nel[12] argues that a system refers to the holistic nature of the knowledge as it links up and relates to all aspects of life and the environment and also refers to the plurality of both its properties and functions. Finally, similar to any discipline, AIKS embody ethical standards, standards of responsibility, transmission and a 'system of rules and practices' [12, p. 7–12]

In conclusion, IKS refers to 'a total of knowledge and practices, whether explicit or implicit, used in the management of socio-economic, ecological and spiritual facets of life',[11] stored in the collective memory and communicated orally amongst members of the community and for the future generations (through stories, myths, songs, etc.).

The nature of the *AmaBovane* with regard to their territory, their belief systems and the value they put on these systems, including nature and animals, gives this group of people a cultural boundedness that is described by Hoppers.[11] Their clarity in theorising and conceptualising how external agents first undermined their knowledges and then overlooked them is a testimony to the value they put on their knowledges and assist in contributing to the reservoir of IKSs, including the struggle of such communities for self-determination and preservation of their knowledges. According to the chief of *AmaBomvana*, new, modern systems of delivering health, religion and education have overlooked their daily cultural practices. Their earth and its vegetation, the living and the dead people of the area, the animals as well as the daily activities of the inhabitants of this indigenous rural community, which contribute to their health and wellness, were ignored. This chief believes that the enforcement of these three aspects by external agents who held assumptions that their communities were blank slates had resulted in a fractured ill community that is blighted by poor health determinants, leaving this community struggling with ill-health and diseases.

According to Jansen,[15] historically, the *Bomvana* people migrated from Southern Natal in the 17th century after experiencing tribal wars for two centuries. The *Bomvana* people moved across the Mbashe River and settled down in peaceful coexistence with the *Gcaleka* tribe in the beginning of the 19th century. In 1856, Mhlakaza, a tribesman of the *Gcaleka* tribe, reported on a vision his niece, Nogqawuse, had. In this vision, the ancestors had promised that if all Xhosa people should kill their cows and destroy all existing grain they had, the ancestors would bless them with new crops and abundant cattle. Most of the Xhosa tribes obeyed this call, which heralded the infamous 'cattle killing delusion'. The *Bomvana* tribe refused to accept this prophecy and moved back to the land they had previously bought from the chief of the *Gcaleka* tribe when they arrived. While most of the other Xhosa tribes suffered famine and poverty because of the prophecy they had obeyed, the *Bomvana* people grew their

cattle, farmed their lands and prospered in this context of *Bomvana* culture.

The highest determinant of health and well-being for a *Bomvana* person was to live and exist as an embodiment of *Bomvana* culture, as a spiritual being who honoured and practised the beliefs of the *Bomvana*. These cultural practices were deeply spiritual and followed a pathway that influenced every action they took. The *AmaBomvana* believe that the greatest indicator of good health is to live and exist as *Bomvana*. To live and exist as *Bomvana*, the following aspects must be ensured: the capability to plough the land and provide indigenous food to the satisfaction of the family; raising, supporting and educating children from conception until adulthood, respectful of their culture and spiritual pathways; living without strife and contention; and brewing Xhosa beer for participating in ancestral reverence to cultivate a relationship with God.

It was with this attitude of pride and awareness of their identities as warriors and self-supporting people that they met the changes that began to happen around them and the resultant acculturation. The first contact of the *AmaBomvana* people with the Western world came as a result of shipwrecks that left foreigners stranded on their shores. Hence, they initially encountered these external influences from a position of power and authority. Following these encounters, new knowledge was introduced by these Westerners in the areas of medicine, religion and education.

Attempts to resist new knowledge and modernity that interfered with *Bomvana* beingness and becoming

Jansen[15] and Mji[7] maintain that acculturation from Western groups who brought in new knowledge regarding health, education and religion was gradually interfering with the *Bomvana* ways of knowing. These changes impacted negatively

on *Bomvana* culture, as while some people changed and accepted the new external knowledge regarding religion, education and medicine, others did not, which split the community into two groups. One group consisted of the educated people, usually Christians, who refuse to partake in traditional practices and are Westernised to some degree (*amaqhobhoka: abantu basesikolweni*), and the group of people, who are uneducated in the Western way, paint themselves with red ochre and remain traditionalists and follow indigenous practices (*amaqaba*).

The existing situation in Bomvanaland did undermine community cohesiveness and health as both groups undermined each other, with both spheres of knowledge appearing to be wielding power. Lately, as this new way of being and doing continued to influence the *Bomvana*, there are those who are rigidly refusing to let go of *Bomvana* ways of being and doing, while others have completely converted to Christianity and completely distanced themselves from *Bomvana* ways of being and doing. In this area, there are also those who practise both knowledges in a charlatan-like behaviour, especially in the area of health, while others have chosen to take the middle road of respecting and using both knowledge systems, although it is difficult because of the strong dominance of Western knowledge, including how it has built its own institutions of practice in the area. An indigenous activist once asked this question: how can Western advocates of religion on their imposition trajectory approach rural villages with the aim of changing their belief systems and build religious structures of Western design which are a far cry from the village structures which they are imbedded in? The church inside Madwaleni Hospital has a strong, imposing presence amongst the rondavels of the Gusi village.

The *AmaBomvana* resisted these foreign entries and continued to hold strongly to their economy. It was cattle diseases and drought, including apartheid laws with land taxes, that ultimately brought the *Bomvana* economy to its knees. Internal changes and requirements by the government of the day forced *Bomvana*

males to become migrant workers; the negative impact of this cannot be underestimated in breaking down the family cohesiveness. One male from one of the focus villages, when we were talking about the need for fathers to play a closer role to their children, asked us: How am I going to do that when I see my child only once a year? From what I have noticed, the *AmaBomvana* are the only black people who still are *amaqaba* and are proud of being classified as *amaqaba* (as they do not have a formal education). As indigenous scholars, such as Gaztambide,[1] Mkhize[3] and Serpell,[4] explain, once a child has assimilated the modern education up to grade 8, there is no turning back –the wound has been opened and the hunger for the unknown persists for life. It appears that part of this group has resisted the Western mirror that was shone in front of their eyes and, like their chief, as he too was *Iqaba*, has conceptualised the brain washing that modernity instigated – the opening of the wound of devaluing and dissatisfaction with the self. Unfortunately, there was a heavy price that this group had to pay. As the wheels of modernity and the so-called civilisation continue to turn, the only areas of formal work that this group could be integrated into were the mines for males and domestic work for women.

The Western knowledge system opting to be an arbiter of all knowledge systems

The colonial powers used brutal policies and devious methods to subjugate the African people in order to acquire full control over their lands and resources. These policies and methods included consistent inferiorisation of indigenous cultures, concerted efforts to erase existing systems of knowledge and their replacement with Western-driven beliefs and knowledge systems. Such pre-mediated policies successfully culminated in, on the one hand, the absolute submission of the communities and stigmatisation of their knowledge systems, with the consequence that most of the communities were trapped in the design of perpetuating their own subjugation through Western education,

Christianisation and degeneration of relatively self-sufficient economies into dependent consumers.[1,2,11] On the other hand, the colonial design succeeded, as it produced the economic imbalances essential for the growth and domination of European capitalism and imperialism. Most of the African countries are no longer led by colonial masters and they have the so-called democracy – but when one looks closely, the colonial agenda continues to replicate itself now having African leaders at the helm.

The ministers of religion that entered Bomvanaland were adherents of the Christian orthodox church.[7,13] Questions are emerging regarding the relationship between Christianity, religion and capitalism. It appears that when these ministers entered new areas with different religious orthodoxies, their aim had been to obliterate them, as they were seen as mediocre and immoral. On the other hand, when one looks at Christian religion and how the *Bomvana* pay reverence to their ancestors, there is very little difference. Christians pray, sing and drink red wine as the blood of Christ as their overarching ancestor as he had died and risen, while the *Bomvana* prepare Xhosa beer, sing and pay reverence to their ancestors as they too see their ancestors as still alive in another realm and, from time to time, when necessary, they bring them to the present. Christianity has a huge financial base; the Vatican (the seat of the Roman Catholic Church) is one of the wealthiest nation-states. Christians have waged wars, manipulated kings and presidents, taken control of certain economies, waged wars against women's rights, kept covert secrets and tampered with religious information to suite their dynasty. Reasons for this are the economic rewards that come with the championing of the main belief system.

Unfortunately, people of African descent fell into this mould of exploitation of the European empire and feudalism, which is European capitalism.[1,2] Together with this came the other dark aspects of capitalism, such as slave trade, imperialism, colonialism, apartheid, neo-colonialism, classifying others as being underdeveloped, although unsure whose yardstick is to be

employed to measure development.[2] These arbiters of power and knowing, such as the Europeans, who accepted Descartes' proposition of developing egos for the Western peoples, which states: 'I think therefore I am', denied that non-Western people could think and make their own history.[1] People of African descent are denied in human history, and ignored and rejected in making their own history, but through the Christian mission of civilisation and modernising the world are first manipulated to see themselves as inferior and to use the European lens to measure themselves. This resulted in hungry non-Europeans who were not sure of the cause of this hunger and used all sorts of measures to appease it, but the hunger was never satiated. For Africans, this opens a colonial wound that cuts across classes, and it is both racial and patriarchal.[1] Africans start framing their thinking along the lines of being weighed by the gaze of the other: I am what I am because of the gaze of the white other.[1] This is the sickness that the chief of the *Bomvana* is talking about, which has resulted in participants of focus group discussions (FGD) 1 and FGD 2 ignoring their IHK and maintaining that they will take all illness to the hospital. When asked for the reason for the said decision, they responded by saying that it is the Westerners who brought all the illness to their villages. This response sounds as if these participants were eluding to more than the actual disease, as they could sense the devaluing, disavowing of their ways of thinking, living and doing.[1,7]

As the new role players of Westernisation dominated the South African landscape, the *Bomvana* and the other black people of South Africa were faced with land taxes, first from the British colonists and later from the apartheid government. The *Bomvana* and the other black people lived in constant fear that the small pieces of land that they were left with, after large sections of their fatherland had been taken away, might also be taken if they do not pay land taxes.[1,12] I grew up in a space and time when black South African families could exist without a single dime in the family, as they always had a thriving vegetable garden, and a field to grow maize, beans and pumpkins. All these lands were at risk if the head of families were not paying land taxes; hence, they had to go to the mines to preserve their lands.

There is a strong link between indigeneity and the land, as indigenous people believe that this is where the spirits of their forefathers rest.[1,7] Europe created and invented international laws to appropriate and expropriate land as Westerners see and think about land in economic terms.[1,2] Now, according to the *AmaBomvana*, the people who said they were the leaders of the spiritual realm – the Christian missionaries – subsequently became merchants and plantation owners, civilisers and developers.[1] The chief expands that if you used indigenous medicine for your health, the same person who saw you at the hospital would be warning you in the church (as the minister of religion in the church was the same person who was the doctor in the hospital) to let go of that Satanic behaviour, while parents that were not taking their children to formal schooling were severely criticised at the church. Marriages were broken if the wife did not want to be converted to Christianity – what a confusing situation coming from enlightened people.[1,2,7]

This Eurocentric way of doing and believing that was imposed on the *Bomvana* opens wounds of inferiority and racism, pushing their own knowledge into the unconscious, imposing a form of being silenced, as mentioned in Chapter 6,[1,8,12] while the pillars that support Western thinking, in the form of churches, hospitals and schools, are being built in Bomvanaland, creating a strong presence. Unfortunately, for the *Bomvana*, as she muses around these three ideologies, global scholars, such as David Korten,[16] warn of the collapse of the Western empire. Below is a transcript, drawn from a passage in David Korten's book[16]:

> The unheeded consumption of the earth resources is starting to exceed Earth's capacity to sustain its inhabitants and is leading to accelerating wave of collapsing environment systems, violent competition for what remains of the planet resources. We are facing a defining moment of choice between two contrasting models: one that continues to support the squandering of valuable time and resources on efforts to mend cultures and institutions that cannot be fixed and must be replaced. The crumbling empire has organized domination at all levels from relations among nations to relations among family members. The present empire brings fortune to few, condemns the majority to misery and servitude, suppresses the creativity of ALL

> and appropriates much of the wealth of human societies to maintain the institutions of domination. (p. 34)

He further expands on this[16]:

> The people of the dominant societies lost their sense of attachment to the earth and societies became divided between the rulers and ruled, exploiters and exploited. (p. 34)

As this game described by Korten[16] continues in the faraway lands of those that see themselves as knowers who hold the globe to ransom, a qualitative researcher stood on the main road of Bomvanaland musing about the changes that are happening in Bomvanaland that were similar to those in Khayelitsha in Cape Town: Facing the Indian Ocean, on my left is Madwaleni Hospital; at the front is a tavern for selling liquor, a 2-min walk from the hospital that the nurses at Madwaleni Hospital visit during tea time and never get back to care for their patients; on my right is a huge supermarket that thrives from the old age pension of the pensioners of this area. When looking critically at these three entities that I have mentioned above, one asks as to who is the winner in this situation, as they all handle the coin, even the place for the sick, and ultimately the coin moves from the gravel roads of Xhora to the South African Reserve Bank and ultimately to the New York Stock Exchange to service the empire.[7,14] It does not matter even if you are the last one on the economic ladder– you still are required to service the collapsing empire.

The older Xhosa women of Bomvanaland complain that since the new democratic government brought this money, they have begun to worry as, instead of this money alleviating their worries, it exposes the short deal that they have accepted, that is, accepting a trade-off – their sons should go to the mines to mine raw materials that are taken to Europe to be refined and returned back to Africa at a higher price than which they were bought from African countries, instead of staying in their villages to plough the fields and feed their families until they reach satiety. As Africa and its peoples, including the *AmaBomvana*, lament around lost identities that lead to lost health indicators, they

need to remember that as long as their gaze has shifted from their lands to the coin, other players will come and play exactly the same game that the previous colonisers played. Lately, we have heard of the rise of other empires from the East. None of these empires seem to have a soft stand towards human rights and dignity, especially for women. In one of these empires, more than a million women made a long chain to protest their being obstructed from entering certain mosques. The Africans also need to check the hand she/he uses towards women. The *Makoti* of one of the elite older Xhosa women says that she wants to be like her mother-in-law when she grows old. When asked why, she responded that she is the birth giver. A birth giver gives birth to both boys and girls and when the earth is in this challenging state – including the situation in Bomvanaland[7] – women need to ask themselves the question with regard to how they actualised both their girls and their boys now that they are in this mess. As the chieftains cry out to Vuyisile asking him who will save his religion, Africans need to remember the role they played in selling their own civilisation. Questions have been raised with regard to who brought the slaves to slave houses, as most African villages were far from the slave houses where the slaves were sold. As the coin continues to dominate, we now hear of stories of the dark head of slavery emerging in places such as Libya with children used to mine Cobalt for renewable energy in the Democratic Republic of Congo (DRC), as highlighted by the CNN Freedom Project.[17] Kwame Nkrumah warned Africans, as they continue to search for a saviour, that neither the West nor the East will assist Africans – Africans need to look straight ahead and face their future.

Discussion on the impact on the *Bomvana* for questioning the modernity script of Western civilisation

This transcript has been drawn from Mji's[7] study.

From a historical perspective,[7] the *AmaBomvana* were proud of their culture and practices. They had their stock and produced their food.[7,12] A majority of the *AmaBomvana* people resisted the influence of foreign entries, including formal education,[7,12] hence, the community is not homogenous and is split into schooled people and those who have not attended schooling. Initially, foreign intrusions of outsiders forced them to compare what they had or did not have, and they started to feel ashamed, humiliated and poor. In the beginning, they defended their culture; this was followed by being concerned whether they are not overplaying the importance of their culture and their identities.[1,2,7]

They started letting go of their daily routine of the household of waking up at 4:00 to do the work that concerns the health of the home. They started losing the purpose for their daily living and investing in their own occupations that build their civilisation. In South Africa, there were many forced removals that were carried out by the rulers of the day to fence urban areas for white people, as only white people stayed in urban areas at that time, while vast amounts of land were also given to white farmers to build wineries in the Cape and in North Transvaal and Limpopo and Zebedial – for the Maize Triangle. Losing of stock and land started, and difficulties in expressing one's culture started feeding into the vulnerability of the *Bomvana*. Questions were emerging whether the head of the family would be able to sustain the family as the whole economy to sustain one's self was lost, and this led to eroded self-esteem and a hunger to be subservient to the other who was different from the self and seemed to be holding promises of success and getting out of this conundrum that the *Bomvana* allowed himself/herself to be dragged into. Migrant labour practices were like a poisoned chalice; on the one side, they were harming their families, while on the other they brought money, which was bringing a different understanding of wealth and poverty; the outcome of this was neglect for the land and mother earth,[16] which was the source of sustenance.

Women lost their purpose of first being the birth givers and knowing that ALL children are cared for by the whole village.

Now we see orphans, the majority of whom are black children being adopted and leaving their indigenous homes, while a majority of women were losing their rightful position of caring for the young and the old. Vibrant, healthy men who left their homes to work in the mines returned home in wheelchairs, while others were falling on their faces because of tuberculosis and coal miners' disease (pneumoconiosis). Beyond siphoning the heads of families to the mines, the young people (who now had the so-called 'education' because their fathers went to the mines), instead of building their villages, move to cities after standard 10. As black people are not chased out of urban areas now, they stand in streets waiting to be picked up for hard labour jobs. These jobs are not different from ploughing the fields back home. The instant gratification and quick-fix mentality draws them like a poisoned chalice to look for jobs in cities.

Back home, women had to head families, and this impacted on cultural roles, values and occupations – women started doing hard labour, which was usually done by men, and developed back problems, and this further compromised their health. Men who had managed to dodge for a little while the falling rocks in the mines and the dust that squanders their lungs came back with smart clothes from the cities and a roll of money that they had faithfully managed to keep to pay the taxes of their forefather's land and make their family happy for a little while. Their wives would still be wearing *umbhanco* – the Xhosa traditional dress. These women also start doubting the integrity of their own culture as the onslaught of the capitalistic agenda started attacking them from both ends – at one end their husbands coming back from the mines rubbing their faces in how backward they had become, while their children who had been hastened to receive education came back from school not listening to them as the lens with which the child looked at the world was changing and they looked at home and its knowledge with disdain.[7] The older elite women cried out: This is slavery, while the chieftain is asking the main chief: Who will save his religion? And, I would like to expand and ask this question: Who will save the African family?

Kwame Nkrumah[18] responded to this question, saying that Africans cannot afford to be looking for saviours whether it is from the West or the East – they need to come forward and trust their integrity. Gradually, these men who go to the mines start losing their sense of belonging, culture and identity, and this is how poverty really starts. While some of these men never came back to join their families, as new relationships developed in their area of work, gradually the female-led households started sliding into poverty if the women did not stand up and fight for the survival of their families. Oddly enough, some of these men who were captivated by the city and the new relationships returned during their last days to be buried at home. I have witnessed this state of affairs numerous times.[7]

There is also a huge dropout rate in formal education. Internal changes and requirements by the government of the day forced the *Bomvana* males to become migrant workers. As already highlighted, the protection of the land is a critical issue in the minds of indigenous people, and although in South Africa, with the breaking down of apartheid, rural people are no longer paying taxes – the culture of working in the mines has not left the people, the minds of people of this area, nor do they have a full understanding of the democratic policies that should serve them. Mamdani, in his inauguration lecture to the African Studies Department at UCT posed this question: When does a settler become a native? He further expands that the new democracy in South Africa needs to be cautious. Using the case study of the Tutsis and Hutus of Ruwanda, he expanded on how those who were oppressed during the colonist era continue to lag behind in these new democracies, as they lack the tools to read the new policies and demand redress. Like in South Africa, how many of the rural people can read the South African Constitution?

During the Marikana episode, there was the cry from the people of Madwaleni, as there were deaths after deaths, and even amongst those who were still alive there was a fear of being killed as finger-pointing continued to happen in Marikana. The *Bomvana* now live below the poverty line,[7,12] with external influences no

longer brought about by the missionaries but by the *Bomvana* themselves as they chase the coin,[1,2,3,4] with the opening of taverns and the drinking by the young and the old alike from dusk to dawn as the chief had eluded. With regard to health issues, I would like to highlight the vulnerability of the IHK focussing on health services in this area. Given below is an outline of how the modus operandi has negatively impacted on the IHK carried by the older and the elite older Xhosa women.

The presence of biomedical care in the area: A blessing and a curse to indigenous health knowledge

It appears that the introduction of biomedicine has been both a blessing and a curse for the inhabitants of the 18 villages of Gusi, as well as for their IHK. The lack of recognition of IHK by health professionals, as well as the attitudes that they display when patients utilise the knowledge is disconcerting. Those who utilise IHK appear to do so at their own risk. Patients feel ashamed of talking about what they have used at home, as the health professionals appear ready to ridicule, embarrass or belittle anyone who has utilised IHK.[18,19] This results in the patients and their relatives not valuing IHK, and they see little need for its use.[7,8,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34]

The above also has a negative impact on biomedicine and person management, as the history of illness and the process of its management is not well-understood by health professionals. This results in the adoption of a non-holistic approach, with those who are close to the health facility showing clear symptoms of their IHK having been weakened, with no replacement with biomedicinal knowledge.[35] The participants who live far from the facility continue to strengthen their knowledge and to manage illnesses that are far more complex.[35] The prevailing situation appears to have no solution, as the government of the day continues to implement fractured PHC services that still concentrate on selective curative PHC, even in

those services that should be offering comprehensive PHC, such as the clinics.[36,37]

Eight clinics had recently been established around the hospital, with a cluster of villages falling under the supervision of each clinic. Linked to the clinics were the community healthcare workers. All the attempts concerned were meant to bring the health services closer to the inhabitants of the 18 villages of Gusi.[38,39] The challenge was the type of healthcare that was offered in the clinics, which had nothing that resembled the culture and the life of the *AmaBovane* people.[12,40,41] The latest threat to the health-related knowledge of the older Xhosa woman was drawing community health workers who were young *makotis* (young wives from the 18 villages of Gusi) to work as community health workers under the supervision of the CNPs who did not value the older Xhosa women for using IHK when their relatives were sick. With the implementation of the eight clinics, with the CNPs as their managers and the community health workers as their foot soldiers, to link the clinic with the homes of the Gusi people, biomedicine had further strengthened its grip on the inhabitants of the 18 villages of Gusi. This could be seen as creating an opportunity, if the community health workers would work hand-in-hand with the older Xhosa women to assist the CNPs to understand the management of health problems within the home.[38,39] The complexity of the social determinants of health to which the older Xhosa women had already alluded in the FGDs showed how ill-fitting the PHC service that had been implemented in the 18 villages of Gusi was to the inhabitants of Gusi.

The revitalisation of comprehensive PHC offers an opportunity to explore the IHK possessed by the older Xhosa women fully, starting from the point of how to be a fully functional *Bomvana*, to assisting one to maintain a good health status. Health professionals who enter the region will have to learn about the culture, and those who have tried to replace, or to ignore, it in preference of Western culture will need to revive it, so as to assist

the health professionals who are newcomers in the area, in order that they might come to understand the culture as soon as they can, in order to benefit the health of their patients.

Change of family structures: Contribution to the weakening of indigenous health knowledge

The older Xhosa women complain about the lack of development in the 18 villages of Gusi. Young people are drawn to work in the cities.[12] The education system itself that has been implemented fails to prepare the younger generation for life in the 18 villages of Gusi. The grandchildren are the IHK trainees of the older Xhosa women. The girl child will move with the knowledge to the next village, in order to enrich it with the acquired knowledge. The present situation, in which youngsters move to the cities once they finish schooling, leaves a knowledge gap, as there is no one to inherit the IHK possessed by the older Xhosa women. Also, the daughter-in-law who was practising IHK on the quiet and seeking to validate her knowledge, through gaining the support of her mother-in-law, might leave to work in the city, die of HIV and AIDS or build her own home away from her mother-in-law, leaving the older Xhosa woman unsupported to practise her healing vocation.

When the parents have died of HIV and AIDS and some of the grandmothers are left with unruly grandchildren, the grandmothers have to assume roles that are beyond their scope of being grandmothers, leaving them little time in which to teach their grandchildren about IHK.[39,40] This leaves a knowledge gap, with no trainees (grandchildren) and people (the daughter-in-law) who have had their knowledge developed so that they can take over the role of the older Xhosa women. The schools in the area need to take cognisance of this and, through the health-promoting programmes,[41] develop school projects that are related to documenting the knowledge for future generations.[42,43,44]

Vulnerability of land: Loss of indigenous herbs and food, resulting in hunger

The IHK possessed by the older Xhosa women is intertwined with the land, its plants/herbs and its waters, as well as with living entities (i.e. people and animals).[43,44] When a woman is pregnant, the eating of certain indigenous foodstuff ensures the mother a healthy pregnancy. Discomfort during pregnancy, such as that which is caused by heartburn, is dealt with by using indigenous foods. When a mother gives birth, she dances and mashes her afterbirth in a private place in her garden to fertilise the garden. On her first day of activity after childbirth, she uses the dung of cows that eat the grass in the village that has been fertilised by the many afterbirths from the village children to clean the floor of her bedroom.[12] According to the older Xhosa women, for every illness there was a herb that was readily available to cure illness, as all the women of the village had contributed their afterbirth to fertilise the soil of the village and its plants.[12]

Nowadays, there are new ways of ploughing using fertilisers that, according to the women, poison the soil, and the cattle are being replaced with tractors. The cattle were seen as being quite gentle on the soil and continuing to be so through their dung that fertilises the soil during ploughing. Also, when the women give birth at the hospital, it is not clear what happens to their afterbirth. This might be one of the reasons why the older Xhosa women resist *makotis* (young wives) giving birth in the hospital.

One of the greatest challenges to the area is the siphoning off of the young men off to mines, leaving only women and elderly men in the village. In village life, mainly young men and boys plough the fields. The siphoning off leaves no manpower for ploughing. At present, the men who find work (despite the high unemployment rate) in the cities work mainly as labourers, as the majority are uneducated. This has collapsed the entire economy of the *AmaBomvana*, which used to depend on pastoral farming.[12] Also, the children attend school and no longer watch the animals

going to the fields, and no longer eat planted items, leaving the plants in the fields vulnerable to destruction by animals. This causes hunger in families, and makes them dependent on the money that their children earn in the cities, which is the main reason why they left the villages. At present, there are unsustainable ways of ploughing that ultimately leave unploughed, vacant fields, because of tractors breaking down and there being no one to repair them.

Nowadays, new shops have food on offer to whose medicinal component the older Xhosa women cannot attest, with the food having already been processed, without them nurturing it during its growth. The buying of food brings hunger, as the older Xhosa women need to have enough money to buy it, instead of ploughing the land to produce their own food. This brings worry, as the money is soon spent. The biggest tragedy about this is, as the current study has already explained, the lack of sufficient resources (in the form of maize and human capital) to make Xhosa beer for ancestral reverence ceremonies.[12,31,32,33,34] This results in angry ancestors who do not support the health of the home, which leads to unhealthy homes and which, ultimately, creates unhealthy villages.

Lack of organised village institutional structures that focus on the building and development of *Bomvana* culture

The education of the *Bomvana* is linked to their land, the elders and the ancestors, and thereby to ancestral reverence.[31,32,33,34,43,44] There is also collective development of the knowledge that appears to be like a maze of cultural knitting that starts in the home and that becomes further enhanced and refined at village gatherings and during the passage through the different stages of being a *Bomvana* and of becoming connected to the ancestors.[31,32,33,34] The *Bomvana* people still celebrate their culture through rituals related to marriage, with the boys coming out of

circumcision, *intonjane* [girls entering womanhood] and *imbeleko* [celebration of a newborn baby], as well as other rituals to reconcile with the ancestors when the home requires such a ritual.[12] What appears not yet to have happened is the bringing out of the knowledge for further open identification and development. Whatever development occurs, happens in informal spaces. The cultural practice of the *AmaBomvana* can exist, but is either not acknowledged by outsiders, or is being eroded by all the above-mentioned challenges. The chief believes that the following three specific areas have weakened and eroded the *Bomvana* culture and the IHK in the 18 villages of Gusi:

- the Christian religion
- education
- health.

The three areas have a clear institutional presence amongst the 18 villages of Gusi (in the form of the hospital and the eight clinics, the Dutch Reformed Church and the over 20 primary and high schools). None of the institutions, according to the chief, draws its underpinnings from the *Bomvana* culture. Instead, it appears that each one attempts to erase from the minds of the *Bomvana* people their culture, as it appears to see the *Bomvana* person as not suiting the culture.[12] This thinking appears to be not far from the thinking of other indigenous people who see their knowledges as being vulnerable to Western cultural influences.[43,44] The influences of education and religion that do not draw from the theories of what makes one a *Bomvana* appear not to be preparing the young people of Bomvanaland to contribute to the culture of being a *Bomvana*. Instead, once they finish schooling, they tend to leave the 18 villages of Gusi for the cities. Those left behind either ignore the *Bomvana* culture or chastise those who appear to be aligned with it. The lack of a critical mass for the development of the *Bomvana* culture is a threat to the continued existence of health knowledge.

The health-related knowledge that is possessed by the older Xhosa women from the 18 villages of Gusi is intertwined with the

culture of being a *Bomvana*. As the older Xhosa women see the culture dying, they feel that their hands are tied and they are angry and frustrated (FG4). The study would not limit the changes that have impacted negatively on the IHK to the Christian religion, education and health, but to modern-day existence. It appears that the problems of modern-day existence rarely draw their solutions from previous experiences but are marked by an immediate response that is governed by a need for instant solutions, using the most modern schools of thought as their knowledge base and literature.[36,37] This is a challenge for the Bomvana culture, as it is characterised by knowledge that is carried by word of mouth. The chieftain of the 18 villages of Gusi has warned against approaching the *AmaBomvana* culture with the aim of cleaning off the slate of the very attributes that are associated with being a Bomvana. It is in this regard that he suggests the integration of knowledge. The chieftain speaks of a backward and forward motion[7] as a solution for bridging the gap between knowledge areas, ensuring that valuable lessons and solutions of the past are integrated in the scope of practice in present times, including the health scope of practice. Perhaps, by bringing health issues, including health determinants, to the *imbizos* of the chief, the 18 villages of Gusi can move forward, while promoting the culture of the *AmaBomvana* as the key culture that underpins the three aforementioned institutions (religion, education and health). We can empower the *AmaBomvana* people to be the active participants in their own health, culture and religion, and continue to develop the theory that underpins their very existence.

A knowledge carried by word of mouth: Neither documented nor researched by Western methods of conducting research

The risk to the sustainability of the IHK possessed by the older Xhosa women from the 18 villages of Gusi has already been outlined.[43] It has already been demonstrated by the two FGs

closest to the hospital as to how they avoided talking about IHK and how they maintained that they were no longer using such things. The fact that the carriers of the knowledge are illiterate means that it stands no chance against biomedicine, which is structured, and which has a clear curriculum. The vulnerability of IHK has already been outlined in the literature review and in the findings of the current study.[37,38] Authors, such as Clough,[8] have challenged researchers on the choosing of what is classified as topical research questions, and that they emphasise the existing status of entrenching the existing models with valid researched information.[39,40] New voices that want to raise attention in vulnerable groups, such as women, children, people with disabilities and indigenous people, struggle to attract attention and funds for such research. Katzenellenbogen[41] complains that, in South Africa, in the past, most of the research conducted in the field of health focussed on quantity rather than on quality and was driven by pharmaceuticals, in partnership with schools of medicine, for trials of efficacy. There were limited studies that focussed on accessing the quality of care, including community and public health-oriented research.[41,42]

The older Xhosa women are dying, and the younger generation is starting to fear being aligned with this IHK. It is suggested that, with the revitalisation of PHC, one of the areas on which to focus should be the revival of the cultural identity of the *AmaBomvana* people and other cultures carrying IHK. To remedy the situation, it is suggested that the model should focus on the very three approaches (i.e. education, health and religion) that appear to have destabilised the IHK carried by the older Xhosa women and the *AmaBomvana* culture.[15] They need to acknowledge the knowledge that is held by the *AmaBomvana* people as being important for their health status and progress.

When the above happens, cultural issues that appear to undermine the constitutional rights of each grouping should be studied carefully for the meaning of that culture to the whole group[43] regarding such practices as the beating of children, the entry of young girls into marriage and polygamous marriages.

The possibility of replacing that culture with a culture that supports the rights of all members of the village should then be considered.

Concluding statement

As already alluded to in the earlier sections, it is up to the *Bomvana* and the other Africans as to whether they should continue lamenting about previous onslaughts, while the colonial agenda is continuing, with them now being the arbiters and colonisers of their own selves and families. It is important to be alert and aware of new knowledges, including the health knowledge that has been brought to the *Bomvana*, and the impact of this new knowledge on the welfare of the *Bomvana*.[7] The *Bomvana* need to also reflect on their own negative contribution made by the cultural practices, and through the backward and forward movement mentioned by the chieftain. The *Bomvana* should also be encouraged to protect and preserve their indigenous knowledge, including IHK, for future generations. The traditional cultural practices that have a negative impact on the health of the communities should be worked upon, and it should also be decided as to how to gradually let go of the practices with a backward and forward movement, as already mentioned.[7]

The older Xhosa women are encouraged to take pride in maintaining an observant and responsive approach towards the health of their families and see how their health knowledge can be integrated into the social life of the 18 villages of Gusi by means of the health services; *imbizos*; village health forums; schools; indigenous rituals; and the churches. The CNP who the South African Department of Health has placed as mini-doctors in primary health services should learn about the herbs and strategies that are used by the older Xhosa women for the management of MHAs within the home setting and should listen keenly to the older Xhosa women sharing their experiences as to how they have managed health problems in their home situation.

The CNP should be willing to teach the older Xhosa women about the aetiology and presentation of diseases, especially those with which they struggle within the home situation, so that they can also learn about biomedical care. The CNP should encourage the early detection of disease and the need to refer to the clinic any patient with a disease who the older women feel that they cannot manage. A bridge of caring should be built between the home and the primary health service (i.e. the clinic) for the management of MHAs within the home situation, in relation to which the older Xhosa women play a pivotal role. Another bridge of care should be built between the clinic and the hospital for the management of the other health problems that the older Xhosa women experience as critical incidents. The CNP needs to work closely with the village health forums to address the social determinants of health. The underpinning principle would be to revive the sense of pride in being a *Bomvana*, so that community members will strive to preserve the health of their community in modern times.

Gaztambide[1] speaks of the central role and contribution of indigenous practises in healing the colonial wound in the decolonial process. He presents a process whereby the decolonial artists go through a process of using artistic sensibilities to transform colonial aesthetics into decolonial aesthetics. As we have already mentioned in this chapter, the colonist no longer needs to be present for the colonial agenda to continue being implemented – the gaze-sickening whiteness continues finishing the job of distancing one from ones' culture, being hungry for something one cannot fulfil, that is, the whiteness that one cannot obtain as it belongs to the other. Gaztambide[1] suggests that decolonial artists want to create beautiful objects, installations, music and multimedia in order to decolonise sensibilities to transform the colonised mind to decoloniality. He names this phenomenon 'decolonial aesthetics', which is made up of images that reject the mirror of the imperial.

Coming to Madwaleni and the coloniality that has occurred there, including the building of the hospital and later the clinics,

and the complete rejection of the IHK of the people of that land, with regard to health issues, the people that seem to have born the brunt of this rejection are the so-called traditional healers that Mji[7] classifies as indigenous healers. Mji[7] tabled a conference whereby the children, the youth and the so-called traditional healers engaged with their oration, their songs and dance using the drums. All this created an amazing, positive energy. Mji further muses whether these three groupings were aware of the positive energy they carried (moving from shame of being dispossessed to pride) and, secondly, were they able, especially the traditional healers, as they were the ones who were directly chastised by the biomedical health services, to connect with this positive energy and heal themselves by being aware of how, as indigenous healers, they are part of a sustainable future as their mode of healing is not adversarial to the environment, and lastly, whether this positive energy can be used in this community that is grieving from loss, as the chief had lamented, for healing and reconciliation and then for emancipating the knowledge and creativity of the indigenous person, which has been pushed deep into the unconscious, for renewal and creativity, and ultimately for future generations.

Chapter 8

Presenting the elite older Xhosa women healers of *Bomvanaland* in the Eastern Cape province

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Introduction

The main aim of this chapter is primarily to present the elite older Xhosa women of Bomvanaland with regard to how they generate health-related knowledge for the benefit of their

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families and communities. Secondly, it aims to outline the challenges and the problems they experience with the migration of younger people to cities and the death of the middle generation with HIV and AIDS and other poverty-related diseases. This has resulted in fractured family units that are struggling to maintain the rightful position of the older Xhosa women of acting as educators of the young in matters of health and spirituality. Keeping in mind the prevailing family structure, the chapter intends to further advocate for support that could be given to the elite older Xhosa women to free their hands so that they could focus on educating the younger generation about the health of the home, including ancestral reverence, which feeds their spirituality. This chapter will use the indigenous lens, including indigenous concepts.

I draw my propositions from an ethnographic PhD study that explored the IHK carried by the older Xhosa women in their home in a rural community.[1] This study revealed a wealth of health-related knowledge carried by the older Xhosa women in supporting their relatives when they are sick. It was further ascertained that these older Xhosa women, when their IHK strategies were not helpful in improving the health status of their relatives, went out of the home to consult other older women who are known in their villages for dealing with the type of illness that had afflicted their relatives. Mji[1] classified these women as the elite older Xhosa women. Elite groups comprise influential, prominent and well-informed people who occupy important positions and whose behaviour is associated with those positions. They are expected to hold the basis of expertise, valuable information and an overall view of the social organisation in their villages. Mji[1] argues that the older people in indigenous communities such as *KwaBomvana* can become more powerful and autonomous in old age, taking on new roles and duties.

The elite older Xhosa women of *KwaBomvana* have shown excellence in the management of the health of the home by

developing a bridge between natural indigenous herbs of their area and the home. They have strengthened the concept of 'humility', health and survival as a collective by sharing their knowledge of healing practices within their community. Lately, the voices of the older people, especially women, are rarely heard in debates about health. Consequently, there is little research that explores the ways in which the older women contribute to the health economy and social capital of their communities. In Bomvanaland, new knowledge holders that have entered carrying knowledge related to health, education and religion have disrupted the quiet existence of the people. The education on matters of health and spirituality that has been delivered to the young by the older Xhosa women has been ignored and sometimes chastised by the biomedical healthcare professionals in the area. In South Africa, with the high prevalence of HIV and AIDS and migration practises, older people, specifically women, have become the pillars of strength for orphans whose parents were lost to AIDS.

This chapter intends to present the elite older Xhosa women of Bomvanaland and the skills they possess in managing the health of the home. Problems related to the instability of the homes and how the healing vocation of the older Xhosa women is at risk because of changing mores will be presented. In view of the challenges that the older Xhosa women are facing, the chapter concludes by exploring how adult education can assist with supporting the older people in managing the pressures, risks and anxieties of modern living. Can new social media and technologies be of assistance for the older people in indigenous communities such as the *KwaBomvana*? Can the existing health and educational institutions in this area join hands with the older people of this community in enhancing the health of the home and how can new technologies assist in enhancing the important role that is played by the older people as knowledge holders and reservoirs of experiential knowledge for future generations?

Knowledge held by the older women for caring and healing in their homes

According to Clough,[2] the talents of women have been carefully integrated into their day-to-day activities, so much so that these talents have been classified and simplified as part and parcel of 'the role' woman are seen to fulfil in society, for example, terms such as 'labour of love' are commonly and loosely used. Boneham and Sixsmith,[3] quoting Gidham, suggest that women's dual roles as caregivers, especially those caring for persons with disabilities, have been underestimated. They claim that a gendered evaluation of health and healthcare is more likely to position the older women in a more positive light and construct the older women as active agents in health matters, especially concerning their family. The role that the older women take on in fostering a spirit of belonging, participation and identification of local assets, such as IHK, in their local community needs to be claimed. Their contribution to the young in facilitating the unlocking of internal power and resilience through storytelling, which further builds character, deserves recognition.

Data on social participation indicate that the older women are more active than the older men in terms of voluntary work, group membership and attendance at social events.[4] In Zonke's[5] study of IHK carried by the older people, male participants were less vocal than their female counterparts during focus group discussions (FGDs). The main qualitative contributors were the older women even though males formed 48% of the study sample. In order to value the contribution made by the older women, they firstly need to be recognised and valued as lay health experts who are regularly consulted by family and friends; and secondly, there needs to be a greater understanding and documentation of the knowledge that these women carry. In addition, the negative assumptions and perceptions about age, gender and ill-health that are entertained by the mainstream society need to be challenged. Mainstream medicine, for example, tends to label the

physiological changes of menopause as being deviant and in need of intervention; this reinforces the societal assumption that the older women are weaker than men and more dependent.[3] Alternative interpretations that suggest that these physiological experiences are a normal part of development need to gain currency.[3]

Bell[6] supports this concept of the empowering role of women, when describing the Australian Aboriginal older women who are the active ritual leaders and the repositories of religious knowledge. They have reared children – not necessarily their own – into adulthood and have acquired the necessary knowledge befitting the status of ritual leaders. Bell[6] explains that in rituals, these women emphasise their role as nurturers of people, land and relationships. Through their *Walwuyu* [land-based ceremonies], they nurture; through their health and curing rituals, they resolve conflicts and restore social harmony; and through *Yilpinji* [the love rituals], they manage emotions. Thus, their major responsibility as ritual leaders is in the areas of love, land and health. As part of their nurturing nature, they see their role as being the custodians of 'the growing up' of people and land, as well as maintaining the harmonious relationship between people and the land. They use certain rituals to affirm their commitment and intention to 'grow up' country and kin.[6]

Struthers[7] calls for an increased awareness on the part of healthcare providers who practise the ancient art of traditional, culture-specific healing and healthcare in their communities. She explains that for a long time in the United States and Canada, it was against the law to practise traditional healing; however, despite this, indigenous healing practices continued to thrive.[8,9] The challenge now rests with how to integrate this knowledge into a highly developed biomedical care model. Previous attempts show that practitioners of the biomedical model are resistant to integration, claiming that indigenous healing practices are generally dangerous; instead, they prefer to influence the traditional side to rather change and embrace biomedicine. However, in specific countries, these attempts have unveiled

what could be interpreted as positive results. For example, Hògberg[10] states that in the Netherlands, Norway and Sweden, low maternal mortality rates were reported by the early 19th century and were believed to be the result of an extensive collaboration between physicians and highly competent, locally available midwives, especially in the rural areas. However, over time, local birth attendants were phased out as biomedically trained midwives were introduced.

Hinojosa[11] shares a similar concern regarding the approach used by Guatemalan health authorities who consistently tried to refashion the vocational framework of Mayan midwifery in accordance with Western medical principles. The ongoing privilege being given to biomedical knowledge created an environment that favoured health personnel and enabled them to extend their influence through the local Mayan midwives into the community. For example, Mayan traditional birth attendants encouraged kneeling or squatting during delivery. However, these positions were frowned upon by biomedical midwives as they argued that with these positions the child descends with too much force and the afterbirth can become stuck within the mother or be expelled onto the ground. Instead, they encouraged the lithotomic position (lying flat on the back with knees raised) or a semi-reclining position. Hinojosa[11] challenges these positions by quoting Jordan, who reviewed the lithotomic position and concluded that it was dangerous because:

1. it decreases the size of the pelvic outlet
2. it negatively affects the mother's pulmonary ventilation, blood pressure and cardiac return, thereby lowering oxygenation to the foetus
3. it lends itself to the mother pushing too hard for too long and thereby becoming exhausted before accomplishing what is required, namely, the birth of the baby, which is sometimes accomplished by external measures such as forceps deliveries or episiotomies.

Through experiential instruction from their own grandmothers and other the older women around them, women have developed,

and continue to develop, various strategies to strengthen their home, including its healthcare needs.[11] Through trial and error, they have used herbal remedies to heal their families and to assist other families in need. The need to recognise and integrate the IHK of the older women into the first level of PHC within a modern health dispensation must be recognised. Scott and Wenger[4] have shown that women's accounts of their health are structured around age and gender. They argue that women can become more powerful and autonomous in old age, and that despite their age, they take on new roles and duties that are conducted in a caring, loving way and with expertise gained from years of understanding, knowledge and experience.[12]

Methodology

The methodology used for this chapter is similar to the one outlined in Chapter 4, with a focus on the secondary study sample that covered conversations with:

1. three elite older Xhosa women
2. family members of the elite older Xhosa women
3. opportunistic transitional conversers (OTCs).

Presentation and discussion of findings

Although 16 elite older Xhosa women were interviewed, only three interviews will be presented in this chapter. Presentation of each finding will immediately be followed by discussion. Data will be presented in the following format:

1. presentation of the three case studies of the three elite older Xhosa women, followed immediately by discussion
2. three case studies emerging from family members of the older Xhosa women with regard to why they are consulted by family members when a family member is sick
3. the chapter will present skills and attributes of the older Xhosa women

4. TOCs regarding their opinions on changing mores and the need to revisit the roles of the elite older Xhosa women.

The three elite older Xhosa women

The three elite older women who will be presented below have been given the following pseudonyms: The keeper of the health of the home and the village; the village political theorist; and the village health practitioner. Narratives are presented with regard to the three elite older Xhosa women.

The keeper of the health of the home and the village

This elite older Xhosa woman was married to the chief of the village. She was much loved by the village constituency, so much so that when visiting her home, other villagers would start walking towards her household wanting to be part of the conversation, and this was sometimes problematic because of ethical reasons. I accord to this elite older Xhosa woman the status of being the keeper of the health of the home as she seemed to have a deep understanding of what is required for the health and well-being at home and in the village. A narrative on how this elite older Xhosa woman described health is presented below:

> Health is to stay well; health is to stay in my house with my children. And to be happy; where there is respect for each other – from young to old and vice versa, no conflict. To work with one spirit, assisting each other. If there is no peace then this affects health. So, there is a need for peace – this undermines health, especially that of the parent in the household. As a woman you are looking after the household of the Mathiles (this relates to the family you have been married to). You do not only look after your own children alone. It is to stay well in your house, be happy in your house and be free. Health is happiness within the household and sharing in the village and being generous and knowing children from the village and taking them as your own. It is to stay well with minimal conflict amongst children. (84, female, elite older Xhosa woman)

She later tried to assist us in understanding the contested polygamy approach in their villages. She addressed the chief's second wife as 'her sister'. We asked her about the circumstances that prompted the chief to take a second wife. She explained that:

> [/]t happened when I went home – my own home to give birth to the second child. In those days, apparently women stayed away from their husbands geographically and sexually so as to recuperate from the birth and to bring up the child. There was a belief that if the wife had sexual relations with the husband before the child was three years old, the child would not thrive well. (84, female, elite older Xhosa woman)

She explained:

> While I was at home the chief could not cope with the household demands and his own personal needs as he was staying with elderly sisters. He decided to take a second wife. Then he came to report to me that he had taken a second wife because his sisters cannot take care of him, they could not even cook for themselves as they were far older than him. (84, female, elite older Xhosa woman)

We asked her how she felt about this; '[a]nger in the beginning but then there was nothing I could do' (84, female, elite older Xhosa woman).

We asked what he expected from her when he told her about this:

> To say what I wanted to say but underneath it felt that he also expected my acceptance. I took her as my sister and it has been fine. (84, female, elite older Xhosa woman)

From the perspective of this elite older Xhosa woman, peace and happiness, not fighting, and producing enough food for all members with families being supportive of one another were all aspects that were viewed as key contributors to health and wellness. Infighting was seen by these women as a lack of health, and as a cause of disease that was in contradiction to the *Bomvana* culture of *ukuhlonipha*. According to them, no one in a healthy mental state would cause infighting and instability within the family and the village. It appears that the younger generation

within the home is taught how to follow rules and regulations, as well as about the culture of the *AmaBomvana*. Support of the development of the child was seen as everybody's duty in the village, but especially as being that of women, which was seen as making a positive contribution to health. Plans were put in place to ensure that during early childhood, priority was given to children having given enough time to thrive, whereby a woman would go back to her maternal home for childbirth and raising of the child until the age of three; unfortunately, some of these methodologies put strain on marriages with new challenges such as polygamy. The health systems existing in the area need to examine approaches such as polygamy, and whether it is still practised during the time of ensuring the health of the child, that is, 3 years, and to work with families on issues of maternal health and modern approaches that could still ensure the health of the child without weakening the marriage.

The village political theorist

This was the early stage of the ethnographic study after I had met with the chief, and I was still puzzled about his assertions that there is an intersection between religion, education and biomedicine in modern civilisation and that these approaches that were introduced and carried by external agents in the form of ministers of religion (as at that time all three would be carried and practised by one person) had brought down the health indicators of the humble villages. The political theorist started to throw light on this matter. There also appeared to be a conflict between the old and modern methods of raising children and this is what she had to say:

> What has brought the whole problem is that they have been told that this is their time. The present time is wrong; the children are told that this is their time now and the future is theirs. Children of today twist messages for their own gain. What differs is that the children of those days were uneducated and they feared their parents and the school. But children of today have outpaced the parents. Children of today will put a case. Once you beat the child

> you become a number in jail. The children are unruly. Children talk back to the grandparents. Children of today do not apologise. They do not have peace. Education has taken away discipline. Children belonged to everybody, even the person who did not have a child. The switch must come back. There is no child without a foundation. They need discipline. Children are disciplined when they are young. Even in the olden days children were not attentive. (80, female, elite older Xhosa woman)

The impact of the migration of the younger generation for work in urban areas was seen in this manner:

> There was a time there was work in the villages, and children were not moving. This time, the child leaves, saying he is going to seek employment. This is still slavery, we are complaining to the children. (80, female, elite older Xhosa woman)

She is aware of their cultural identity that required the wearing of traditional clothing, including village life that required all to work hard, as there were large families to feed, as can be seen in the following statement:

> As you know, we are the people of the red blanket; we are not like the people from the urban environments. In town, you open the tap, use electricity; everything works hard on your blood. Here, groceries get finished before time. You must dish up for everybody. (80, female, elite older Xhosa woman)

The elite older Xhosa women are struggling with the new methodologies of raising children that have been brought by the new democracy. No support is given to parents, for example, if they have to stop punishing their children, then how should they manage a delinquent child? Also, in the minds of the elite older Xhosa women, children leaving for the urban areas was seen as a challenge for the development of their villages, as children after being raised to adulthood were in turn expected to assist in building up the home and the village. Cook, cited in Jansen,[12] in writing extensively about the education of South African tribes, was concerned about the lack of vital connection between the schooling and the life of the tribal community. Many of the younger people were found to no longer be wearing *imibhanco* (i.e. the cultural red blanket that is traditionally used

as a dress) and, once they completed high school, they left for the cities. A generation gap is consequently created with the grandmothers having no one with whom they can validate their health knowledge to ensure that a newcomer will fill their position once they are no more.[5,13,14] The result is a gap in terms of how health knowledge will be retained. The elite older Xhosa women saw the above as a form of slavery, as their children left to work in the cities during their most productive years, with some never returning to their original homes.[12] In addition, those who did return were alienated from their cultural identity that required the wearing of traditional clothing, and from village life that required all to work hard, as there were large families to feed. This raises questions with regard to the exodus of young people from rural areas to urban areas once they complete their education. Two questions emerge, with the first one indicating a need to evaluate how much the education system in rural areas includes concepts and principles of the culture of rural life, and secondly, how much development is happening in rural areas and why jobs are not created in rural areas that will retain younger generations in these areas.

The elite older Xhosa women thought that life in Bomvanaland was different from urban life, with the former being more difficult, as they lacked amenities such as electricity and tap water that were available in urban life. Such amenities are at the core of PHC, and should be facilitated by the personal care service point, such as the clinic, that is nearest to people's homes.[15,16] The plan to revitalise primary health is commended, as doing so might help to satisfy the, as yet, unfulfilled promises of 1994, that is, improving access to PHC, especially in the rural areas.[17,18] It is hoped that doing so will include the opening up of job opportunities for the village youngsters, so that they will not feel compelled to move to the city.[15,16] A good place to start would be to assist the said young adults with digging of boreholes and providing running water for their villages, as well as constructing toilets for their homes.

The village health practitioner

This elite older Xhosa woman was quite aware of the interdisciplinary work required in the management of the health of the home, as she mentions that when people come to her for health matters, she handles each case individually and her approach is to observe whether the person needs herbs, a spiritual approach or the care of the hospital, and if she feels her skills are not sufficient to support the person, she will refer the person to where she thinks the case will be best handled. Some abstracts drawn from her approach to health conditions presented to her are listed. In relation to her management strategies of health problems that were referred to her, the following is what she had to say:

> In general, a person takes a week or slightly more. What is important is to see a person getting better. The one with diarrhoea with blood stains, the diarrhoea must get better and the blood stains must stop and the one coughing out blood this must stop and the sputum should be clear. (78, female, elite older Xhosa woman)

She saw early diagnosis and referral as important for good outcomes:

> When an illness has not been dealt with quite early it is difficult to cure. If you start a person on medicine, one bottle should be enough if you are going to assist a person. When a person is doing better – a person is given a certain medicine called *mafubuka*, that medication clears the stomach. (78, female, elite older Xhosa woman)

She seemed to contradict the perception of biomedicine that indigenous medication is given without consideration for dosage and frequency, as is shown in this extract, stating that '[y]ou grind them and put in a bottle with cold water and a person drinks two tablespoons three times a day' (78, female, elite older Xhosa woman).

She was quite aware of diagnoses related to the chest, as indicated when she states that '[y]ou do get chest problems even if you are not coughing. The chest becomes closed

and shows signs of breathlessness' (78, female, elite older Xhosa woman).

She was critical of some of the hospital management approaches:

> It is bad that in hospitals a woman is asked to lie on her back when giving birth. You need to breathe deeply from the bottom of your stomach. You must call the birth process from afar, deep in your stomach. How can you achieve this with the stomach not allowing you to breath? (78, female, elite older Xhosa woman)

The village health practitioner seemed to be ahead of her league on health matters and caring of the home as she positions herself within an interdisciplinary paradigm of healthcare. She was also critical of the management skills of the older Xhosa women in their home situation. She spoke of the need to not use certain herbs as people's immunity had declined. These herbs, especially those for stomach problems, could exacerbate the condition. She spoke of how corrosive the sea water is and that it can make diarrhoea worse, especially in people with HIV and AIDS. She was challenging old perceptions, namely, that the elite older Xhosa women blindly manage their sick relatives and neighbours – one could see how she uses what is classified as differential diagnosis in biomedicine in assessing the improvement of her patients, as the statement below explains:

> In general, a person takes a week or slightly more when you as the older Xhosa woman are managing the health problem. What is important is to see a person getting better. The one with diarrhoea with blood stains, the diarrhoea must get better and the blood stains must stop, and the one coughing out blood, this must stop, and the sputum should be clear. (78, female, elite older Xhosa woman)

It appeared that the caring attribute also assisted the elite older Xhosa women to decide while using IHK strategies as to which activity to focus on first.[19] The elite older Xhosa women mainly preferred disease prevention and health promotion according to how they saw the health of the home, as well as that of the village, could be maintained, rather than intervening when a health problem had already manifested. Therefore, they busied

themselves with a myriad of activities, including monitoring the health status of the home and their family, to ensure that the health of the home was guaranteed.[2,3,4,20,21]

The family members of older elite women

This aspect covered perceptions of family members with regard to why their mother/grandmother/mother-in-law was respected by the village for her healing practises. For the first interview in this section, the grandmother who was an indigenous healer refused to be interviewed and instructed her trusted 25-year-old granddaughter to speak to me. This is common, as the older elite Xhosa woman sees herself as a specialist and that her IHK has been transferred to her trusted granddaughter.

The granddaughter's perspective on her grandmother

Granddaughter: Our grandmother's healing gift continues to grow; it is not becoming extinct. The people who used to come to her used to get better. The only problem is that they do not pay. She would give medication to the children.

Interviewer: What ailments does she deal with?

Granddaughter: If a person brings an ailment and gets medication from grandmother, that person gets well. The white illness is far more complicated and expensive. A person loses work. Our grandmother usually asks for appeasement from the ancestors. Our grandmother does not go to church. She goes to the church of being a traditional healer. Our grandmother is a person of the spirits. Other religions are in conflict with her spirit. When she wants to evoke her spirits she asks for hands from the neighbours – that

means the neighbours join in her calling of the spirits by clapping their hands. She also has a drum. The neighbours also come to grandmother when they are sick.

Interviewer: Does your grandmother ever ask anyone to go to the hospital?

Granddaughter: Yes, she knows what is suitable for her.

Interviewer: Does she not send them to other traditional healers?

Granddaughter: No, she oversees this herself, and if it is more than her capability, she sends the person to the hospital. My grandmother does not see the contradiction between what she is doing and the hospital; she sees these as complementing each other.

Interviewer: Do you foresee a time that your grandmother's medicine could be used in the hospital?

Granddaughter: No, the doctors reject Xhosa medication. When you go to the hospital, they ask you if you have used Xhosa medicine. Then they ask you why have you come here if you can medicate yourself? There are people who react badly to Xhosa medication. The most important thing is that one must first use one type, preferably Xhosa first. The medications do not mix. My young child reacts badly to Xhosa medication.

Interviewer: Who are the people who have been helped by *Makhulu*?

Granddaughter: There is one, he woke up from the deathbed and another mother who was struggling to give birth.

Interviewer: Which medications do you know of?

Granddaughter: *Ingcimamlilo*: for burns and wounds. *Usikhikhi*: for rash and earache. *Ingcelwane*: for stomach ache. When I am not doing well, I go and pick up medication; and if I do not recover, I go to the hospital. *Umlungu mabele* is for the worms – it burns them so that they do not come out through the mouth. Peach leaves are also helpful. You boil them. Peach leaves are also helpful when animals have wounds. *Umjelo*: for cramping stomach. When you have palpitations, you can also chew *umjelo* – its bark. The roots of *ubazi*: this helps with the placenta that is struggling to come out.

Interviewer: What makes your grandmother a healer?

Granddaughter: The greater people gave her this gift. Spiritually, she is helped to see the medication while sleeping. And then she wakes up to seek for it and heal people. This started with her father. I am not sure whether it is still her father who gives this to her through a dream.

Interviewer: How do you handle this whole healing thing of your grandmother?

Granddaughter: We are a bit careless about it; it is as if it is like the groceries, which will always be replenished when they are finished. We forget that one day she will not be there. Children do not watch when she selects these medications, but she also teaches me, although I struggle to understand them at the same time

The daughter-in-law's perspective on her mother-in-law

After having an interview with the elite older Xhosa woman (see the earlier section, 'The village health practitioner'), we interviewed her 28-year-old daughter-in-law:

Daughter-in-law: My mother-in-law is the one who stands up when somebody is not doing well. She picks herbs. Other herbs she plants. Sometimes she is called to other households when somebody is not doing well. What makes her be a mother is that she moves fast and what makes her move fast is that she has patience. I start with my mother-in-law when my child is sick. Children do not watch when she selects these medications, but she also teaches me, although I struggle to understand them at the same time. Others she plants.

Interviewer: Do you not want to do this for yourself sometime?

Daughter-in-law: I am afraid that I will not mix it the way mother mixes it.

Interviewer: Is there a time when your mother-in-law helped a person who was very sick?

Daughter-in-law: Yes, sometimes mother is called next door. The person had dyspnoea, and the person died. She assisted one grandfather.

Interviewer: Do you sometimes give a child who is not doing well to your father-in-law?

Daughter-in-law: No, it is the mother who we trust and who jumps first. A person who is the father is hard. A mother is like this because she is the birth giver. I too am patient, and once I am old, I see myself having the same qualities.

The grandchildren's perspective on their grandmother

We arrived in a household while the elite older Xhosa woman was visiting somewhere and while we were waiting for her, we had an opportunity to speak to the grandchildren. This was a steady household that looked as if they were managing to handle their struggles and were coping. We wanted to hear from them why we were referred to their grandmother as an elite older Xhosa woman. One young man seemed to be the closest to the grandmother and was more vocal. He told us:

> Our grandmother explains to me where I should go in the garden and sometimes in the field and the forest. She explains exactly how the herb looks like so that I would know what to pick up. We like our grandmother a lot as she keeps the peace of the family and keeps the family together. (9, male, grandchild)

The above case studies further affirm the role of the elite Xhosa women with regard to being trusted as far as the well-being of the family is concerned, and of being consulted when a family member is sick.

From the description given by the other family members of the elite older Xhosa women, there were many metaphorical balls that they juggle and keep afloat to sustain the health of the home.[22]

One of the daughters-in-law of an elite older Xhosa woman described the latter's movements when she had to manage a health problem. The daughter-in-law sometimes appeared to contradict herself, as one would tend to think that moving fast cannot be combined with patience. It seems that the elite older Xhosa women were in touch with their instinct of caring and preventing harm from happening in the family, as well as with their ability to help relieve pain and suffering, even during moments in which they need to rush, utilising whatever measures were available to them to save a situation.[12,19,23] One of the cornerstones of the ethics of healthcare is preventing suffering and doing no harm (key informant from Kwame Krumah

University of Science and Technology, Kumasi, Ghana, pers. comm., 16 June 2008). From the current study, it emerges that this is the caring skill that the elite older Xhosa women were taught at an early stage in their lives. The daughter-in-law saw her mother-in-law as somebody who jumped first. She did not say that because she has given birth, she jumps first – she says as the birth giver she jumps first.

To the author, this conveys an understanding of why all the women in the village, including those who gave birth and those who did not, were seen by the villagers as the carers for all the children of the village. The researcher thinks that jumping first requires a combination of skills that are both learnt and personal attributes. The caring approach of the *AmaBomvana* elite older Xhosa women appears not to be very different from the approach taken by women in other parts of the world. The Aboriginal women of Australia dance with their hands cupped, showing that they assist with the growth of their children, foster love in the home and look after the health of the people and the land.[6] Clough[2] maintains that pregnancy, giving birth, raising children, caring and nurturing are part of being a woman. Murdock[23] equates this to being like a guide to the mysterious realms of the feminine.

Achterberg[20] argues that the caring approach of indigenous women towards their families is hardly different from the approach taken by the women of the Northern and Western worlds before their healing practices were institutionalised. It appears to Clough[2] and Murdock[23] that modern women continue to practise their healing vocation silently, without acknowledgement with regard to the time and resources that are spent on performing these roles. Achterberg[20] classifies this as the institutionalisation and industrialisation of the healing vocation of women. Clough[2] describes this as the double burden that modern women have to carry, as they still continue to look after the health of the home while also being integrated into the formal job market. In the current study,

the family members of the elite older Xhosa women, all confirmed that the best person to look after health issues at home was the elite older Xhosa woman.[5,21,23] Such thinking is supported by Achterberg[21] and Clough,[2] who both claim that women have always been healers and carers, while Boneham and Sixsmith[3] admire the skills that women develop as they grow older and which they use in their families and the surrounding communities in assisting them to cope with the challenges of daily life. Unfortunately, such reciprocal support is perceived to be lacking for the elite older Xhosa women because of migration to the urban areas and the breaking down of family units.

Gibson[25] argues that women, as carers, do not receive assistance from formalised home care services. The lack of recognition of the caring role of women for the sick and their families has already been mentioned by researchers such as Achterberg,[20] Murdock[23] and Clough.[2] This is the situation in which the older Xhosa women find themselves in relation to the health facilities of the 18 villages of Gusi, in terms of which the health professionals first fail to recognise that the women have tried to do something when their relatives were sick, and instead chastise them for using IHK. In response, the women hide their knowledge, and do not inform the health professionals of what they used or are using.

The caring skill that helps maintain the health of the families of the older Xhosa women appears to resemble the caring and empathy that they hope to find when they visit the health services of their villages. Unfortunately, it appears that, for whatever reasons, unlike the older Xhosa women from the villages of Gusi, the majority of health professionals do not see the necessity for developing an interactive reasoning regarding what their patients require from the health service, referring to being heard and acknowledged as a person who reasons and acts when they are faced with the problem of sickness in their families within the home.[5,23,24]

BOX 8.1: Summary of attributes and skills from the perspective of the family members of the elite Xhosa women.

Attributes and skills from the perspective of the family members of the elite older Xhosa women:

- A teacher and a role player.
- A trusted person who is patient and inspires one and keeps the cohesiveness of the family.
- Moves with sense of purpose: what makes her a mother is that she moves fast, and she moves fast because she has patience.
- Self-confident, aware of her limitations and consults others who are knowledgeable – if an illness is beyond her capability, she sends the person to the hospital.
- Draws energy and power from ancestral relevance and support from neighbours.
- A vulnerable knowledge that is observed, practised and carried by word-of-mouth:

  "We are a bit careless about it. It is like the groceries which will always be replenished when they are finished. We forget that one day she will not be there" (*Granddaughter of one of the elite women*)

Source: Mji.[1]

Transitional opportunistic conversers

Contribution to the different understandings of the elite older Xhosa women, the vulnerability of the IHK in the advent of changing times:

Two young wives

They complained about the control of the mother-in-law on them. To them, their mother-in-law appeared to utilise her

health knowledge and the knowledge she holds about their husbands as a form of control on them. One had left her husband and was staying on her own, while the other is thinking of leaving the mother-in-law's household to start her own household.

This extract brought a new perspective on how the attributes of the elite older Xhosa women might be perceived by the wives of their sons. It showed the impact of change and new models of practice emerging in the village life, and demonstrated the importance of not generalising.

☐ Retired clinical nurse practitioner

They narrated stories of:

- Young nurses taking patients out of the hospital for IHK intervention.
- Traditional healers begging for body parts excised from white patients during surgery for preparing medications.
- Blames the mothers of children that die of diarrhoea for using bottle feeding.
- Awareness of the vulnerability of both the indigenous and biomedical knowledge – this also could be indicative of the fact that amongst the biomedically trained staff, there are health professionals who have integrated both biomedical and IHK practices.
- Awareness of double standards of local health professionals.
- Recognition that traditional healers know where the power lies.

☐ Clinical nurse practitioner from one of the clinics

The clinical nurse practitioner from one of the clinics is upset by the health-seeking behaviours of the people of Gusi that brings all illnesses to the clinic, even illnesses that could be classified as minor health illnesses. According to her, the people of *Bomvana* are going to lose their IHK for the management of minor health illnesses within the home situation.

Transitional opportunistic conversers and emerging health-seeking behaviour

These TOC contributions evoked in the researcher a new awareness about emerging health-seeking behaviour, including the confusion between levels of care for different conditions. The blaming approach and pointing of fingers from both the providers and the consumers of biomedical healthcare continues.

Some of daughters-in-law appear to think that the older Xhosa women are not aware of the need for emotional support that the daughters-in-law have, as they continue to do the hard work at home and to support the elite older Xhosa women by doing physical chores at home. The young wives in TOC1 had already shown that the daughters-in-law questioned the superior role of the older Xhosa women. This again links with Mashile's[19] perception of the need to support women as they carry out their caring tasks. Kanter[26] expands on the outsider's role and the need for the outsider to contribute to the well-established male-dominated environment. The current study has already alluded as to who controls the homes in the Gusi villages. The older Xhosa woman understands that, to keep the tranquillity and the health of the home, she has to keep the man of the home happy and ensure that he is respected by his young wives. The situation appears to be no different from that of the male-dominated health institutions, where the CNP practises what she has been assigned to do in assisting the doctors by acting as a pseudo-doctor for MHAs. As Mash[27] explains about the role of the CNP that will continue to be redefined, it is hoped that assuming the role will not distance the practitioner from her caring role. It appears from the current study that all women from the 18 villages of Gusi, including those who were health professionals, required support as they carried out their heavy burden of caring.

Recommendations

This chapter emerges against the backdrop of challenges faced by indigenous people on how foreign entries that entered their quiet existence undermined their prior knowledge, especially in areas of education, religion and health. There is a strong institutional presence in these areas in *Bomvana*. Despite this, the elite older Xhosa women have persisted in supporting their homes in matters of health. The changing village mores, such as unruly grandchildren, charlatans mimicking their healing vocations, health systems that do not focus on health determinants and the health of the home, have exposed the vulnerability of the scope of practise of the elite older Xhosa women. It is also unclear as to how long the elite older Xhosa women will enjoy the status of supporting the daughter-in-law, who was the central person in observing the skills and in silently practising them,[2] in the latter's preparation towards assuming the role of being an elite older Xhosa woman in the future. The usefulness of this role was already starting to be questioned as being inhibiting and controlling by some daughters-in-law. Currently, some leave the older Xhosa women alone, so that they can go to work in the urban areas, as some husbands do not return after leaving home to work in the cities, while certain daughters-in-law are dying of HIV and AIDS.

This type of situation is not assisted by the much-acclaimed post-1994 PHC strategy, as the strategy ignored the community-based assets, such as indigenous health carried by the elite older Xhosa women, as well as considering the impact of free health services for communities that earlier struggled to gain access to formalised healthcare services. It is within this paradigm that these PHC services are left open to charlatans and health professionals who complain of patients overcrowding the services instead of using IHK – the question that needs to be asked is: Are they not the same health professionals that chastise patients who have used IHK? It is within this space that the researcher

perceives that the health professionals should take the caring approach that is practised by the elite older Xhosa women – this approach will assist in lifting the veil of secrecy with regard to the elite older Xhosa women who utilise IHK when a relative or a neighbour is sick. This should be paired up with the strengthening of the PHC systems as the ministrations of the elite older Xhosa women are required at times when there is no transport to take the person to the biomedical health system. The availability of public health transport, such as ambulances, is still an issue, especially in rural areas. Within the democratic dispensation, in the spirit of decolonisation, reconciliation and transformation, this chapter further recommends that the care given by the elite older Xhosa women be recognised as an important, integral part of a health environment. Both the inhabitants of the Gusi villages and the health professionals concerned should design a plan for how to revive the caring element in their health facilities. A good place to start could be to listen to the elite older Xhosa woman as she narrates the steps in caring that she has taken in managing the health problem of the relative that they brought to the health service. The reciprocation should involve explaining to the elite older Xhosa women about the biomedical care that is going to be given to their relative. This would assist the elite older Xhosa women, who are discouraged by biomedical health practitioners from using certain indigenous health approaches at home, to start learning about biomedical health practises and employ them in place of their indigenous health practises.

The school system is one of the institutions that could intervene, as it struggles with the process of decolonising the curriculum and integration of indigenous knowledge. The elite older Xhosa women see the education of the young, especially in health-related matters, as a vehicle to achieving healthy homes that in turn make healthy villages. They are also concerned about the lack of inclusion of educational concepts that are underpinned by their rural life, which results in the migration of younger people to cities. It is within this paradigm that rural homes could be used as spaces of apprenticeship, whereby the younger generation

could enter the rural homes to learn about skills from the elite older Xhosa women, while on the other hand they can assist the elite older women with new technologies. These new technologies could further assist in bridging the gap between the school system and the homes, whereby case studies of younger people learning within the homes could be documented and played back within the classroom situation for further analysis of the key aspects learnt from that exposure. This process could be used as one of the vehicles in decolonising the curriculum.

Concluding statement

The elite older Xhosa women of *KwaBomvana* have shown excellence in the management of the health of the home by developing a bridge between natural indigenous herbs of their area and the home. They have strengthened the concept of 'humility', health and survival as a collective by sharing their knowledge of healing practices within their community without duress as they understand the power they have towards the young as elderly people.

Unfortunately, their role of caring for the young is under threat as the elite older Xhosa women face challenges and problems of migration of younger people to cities and the death of the middle generation with HIV and AIDS and other poverty-related diseases. This has resulted in fractured family units that are struggling to maintain the rightful position of the elite older Xhosa women of acting as educators of the young in health and spirituality matters. In the prevailing family structure, the chapter intends to further advocate for support that could be given to them to further free their hands so that they could focus on educating the younger generation about the health of the home, including ancestral reverence, which feeds their spirituality.

In view of the challenges that the older Xhosa women are facing, this chapter concludes by exploring how the elite older Xhosa women could be supported in managing the pressures,

risks and anxieties of modern living. Can new social media and technologies be of assistance for older people in indigenous communities such as the *KwaBomvana*? What about the more than 20 schools that exist in the area; could young people, as part of their learning assignments, visit and assist the elite older Xhosa women with activities requiring strength, as well as how to use technology-related materials to alleviate some of their load, while on the other hand the elite older Xhosa women continue supporting the young people with education about their culture and other spirituality-related aspects during these visitations.

SECTION 2

Translation and application of PhD critical research findings on the research site

The backward and forward movement – Trying to find our limbs

Description: Homes that the Bomvane people built with their hands using natural resources from their land, as well as their food and livestock.

Chapter 9

Steps taken to translate critical research findings

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Introduction

This chapter presents the background and the context-related factors and outlines the process of creating an approach and a framework towards the translation of research findings. It further highlights the inputs from indigenous scholars in making meaning of the translation of research findings.

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Background and context-related factors

Critical emerging aspects about the *AmaBomvana* and their context

The initial investigation into the health problems that were managed by the older Xhosa women in Bomvanaland was a bit of a bumpy road. The knowledge holders adopted the research question and made it their own, with the researcher giving full freedom to participants to shape the findings according to their interpretation of the research question. The older Xhosa women resisted talking about health problems they manage at home; instead, they gave long stories about how they manage their daily lives (activities and rituals they carry out to manage a day, including resources they used). It was only later that the researcher understood that these older Xhosa women were answering the researcher from their own understanding of health and illness and how to manage such problems within the home situation. They spoke about the day and how to manage the day so that you have a healthy day that contributes to positive health indicators. They described health as life, and without health there could be no progress in their villages. They saw broken and unhealthy relationships in their community at the core of ill-health. Respect between the old and the young was seen as the glue that prevents infighting (because according to the older women, fighting causes ill-health. especially that of the home, and healthy homes make healthy villages) and ensures stability in the community. Food security and food production were essential for health so that families can have enough food for each of their members to reach satiety. Peace in the village was critical, and it was the responsibility of each home to assist the villagers in educating the children about respect and culture of the *AmaBomvana*.

The older Xhosa women saw awareness of their cultural identity as an indicator of wellness. At the helm of this preservation of the health of the home is the older Xhosa woman, knitting a mosaic of

skills, knowledge and attributes for the family. The home for the *Bomvana* family is seen as the nucleus in which health is maintained and illness is contained, and the older Xhosa women play a critical role in ensuring that family members obtain optimal health status. The migration of the younger generation to the cities, resulting in the further collapse of the *Bomvana* rural economy, appeared to deepen the struggle that was faced by the holistic approach to health followed by the older Xhosa women. The biomedical healthcare services that have developed within Bomvanaland had brought both rewards and tensions to the area, as the older Xhosa women struggled to find a place for their knowledge within the new health system. They also lacked modern educational skills to gain access to this new health system. Somehow, this health system has distanced itself from the health system that existed for generations in this area. It appears that the health system in this area focusses on diseases and the process of curing them without understanding the carriers or underlying causes of the diseases and environmental factors (i.e. land, culture and available resources to maintain and improve health indicators). Some of the key indicators of ill-health in these villages, such as the migration of people to cities looking for work, appear not to be an issue for the health professionals in the health institutions in this area – it appears that they mainly utilise the curative approach to healthcare.

Madwaleni is a lovely area with beautiful rolling hills. The weather in this area is reasonable enough for families to start producing their own food from either small- or large-scale farming. There is a reasonable number of animals for both ploughing and consumption. There are many children to be kept occupied with some form of purposeful activities that are linked to the development of the villages. There is a large number of schools – it is not clear what is being taught in these schools as this was not the focus of the study – but according to the older people in this area, the school system in this area is not focussing on learning activities that could build the villages, as it is not drawing from the prior knowledge of the people of the villages. There is a noticeable absence of the middle generation, especially

men, as some have been drawn to cities for work and some have been wiped out by mainly HIV and AIDS.

Two health systems continue to run parallel to each other, with each believing itself to have the correct solution to address the health needs of this area. Relationships between the two are poor and levels of trust are low. The biomedicine appears to have high moral ground with regard to knowledge of healing, language, culture as well as aspects of spirituality. With regard to the indigenous health system in this area, there is a whole health belief model that is based on relationships; there are the indigenous herbs; there are the older women (elitist women) who are consulted by other older women when their health strategies appear not to be working at home – approximately three per village; there are also traditional healers; there are rituals that are practised from birth to death and follow all stages of human development.

Lastly, there are the ancestors – the relationship with ancestral life in Bomvanaland is the ultimate concern to which all social aspects of life can be referred. The availability of the indigenous healers in this area offers an incredible space for gaining an in-depth understanding of the explanations used by these healers in their understanding of health and illness; the biodiversity, including herbs; the environment; as well as the relationship that the *Bomvana* has with its peoples, animals and lands. One cannot underestimate the existence of the biomedical system as an asset in this area – the next urgent step now is how one works a system whereby each respects the other.

Creating an approach and a framework towards translation of research findings

Before we started creating a plan for the translation of the research findings of the PhD study[1] on which this book is based, we were aware of approaches and quests of previous attempts to address inequities and improve the health of communities. These previous attempts had focussed on gathering information on

what works from a deficit point of view. In these quests, there has been a tendency to focus on identifying the problems and needs of communities that require professional resources. This creates a high level of dependency on hospital and welfare services and leads to policy development that focusses on the failure of individuals and local communities to avoid disease rather than the potential to create and sustain health.[2] Despite calls for all health policies to be equity-proofed, many cross-government policies are implemented without adequate attention to their impact on health inequalities. When the principles of equity and social justice are lacking in a society, social inequities result. These result in being expressed as differences in health amongst individuals. In order for the differences to be seen as injustices that need to be corrected, a value judgement must be made. Targeting only poverty does not result in resolving inequities. One might even end up deepening and reproducing inequities.[3]

Addressing health needs only in a medicalised manner merely deepens the health problems and inequities. For example, a patient who waits the whole day at a CHC for a Panado while children are alone at home with no one to give them proper guidance could create other health problems during this time. If equality of opportunity is not possible, and there is no way to counter social inequalities for healthy communities, then the aim should be advocacy so that people are not disadvantaged and left behind in their struggle to achieve their full health potential. From this perspective, some schools of thought and models have emerged. These models all point to what is already available in the community. The researcher will discuss four approaches or models that she perceives influenced the thinking in coining a strategy for the translation of the PhD findings.

The social capital model

The first model is the social capital school of thought. It is related to the school of health creation, whereby communities, through the creation of interconnectedness amongst themselves, create health. These are the fruits of the people who contribute towards health.[4,5]

Social capital refers to the processes between people, which establish networks, norms and social trust, and which facilitate coordination and cooperation for mutual benefit by investing in social capital. This is as important as the other forms of economic investment, especially financial capital. PHC and health promotion would not work by merely bringing in new programmes or campaigns. Rather, what is important is, firstly, to identify these networks and start working to strengthen the existing networks by encouraging them to work on health issues whenever possible.

The starting point would be to ask, 'how are you addressing health, rather than what are your health deficits?'[4] Primary healthcare and health promotion specialists should ask themselves questions such as 'what creates health?' They will find the answer rooted in the social and economic structures of society rather than in healthcare services.[4,5]

BOX 9.1: Determinants of health according to the social capital model.

- A reasonable standard of living that supports people in playing a useful role in society and maintaining social relations.
- Relatively equitable distribution of goods (income, housing, education and healthcare).
- Minimal hierarchy between people (evidence from UK civil service studies suggests that hierarchy itself is bad for health).
- Healthy physical environment with minimal pollution of air, water, soil and food.
- Social support and protection from unwanted social isolation.
- An engaged civic society in which people are able to participate (women's groups, social activity groups, etc.).
- Health services (but these play a minor role in creating health).

Source: Baum.[9]

Surely, it follows that the core business of PHC and health promotion should be working to bring about these conditions in society.[4] The focus shifts to groups and organisations rather than to individuals. In this shift from a focus on disease, the intersectoral links become central rather than optional extras.[4,5] Yet, when the World Bank invested in health, it considered the importance of investment only in economic-related development and neglected the aspect of community development. It did not realise that it was doing this at the peril of sustainable economic development.[4,5,6,7,8] The Alma Ata Declaration of Health for All in 2000 put more emphasis on and called for social investment to achieve equity in health. Social capital provides a new way of thinking about this work. Social capital attempts to engage with the over-reliance on economic factors in public decision-making.[4] Fran Baum,[9, p. 123] in her 1997 speech at a conference whose theme was to lighten the burden of developing countries, calls on us to imagine what would happen if every night on television, instead of hearing about the Dow Jones and *Financial Times* indices, we were to hear about levels of social trust that have developed or

BOX 9.2: Social capital building.

- Participation: Who, what, why? Who does not participate, and why?
- Levels of trust.
- Sufficient time to engage in village or civil activities.
- Types of group activities.
- Networks of links between people and groups that encourage active participation, mainly outside the health sector, and health professionals would act as support groups.
- Structures for building social capital (e.g. public meeting places, public broadcasting networks, links between state-funded and community organisations).

Source: Baum.[9]

the number of new community groups that were springing up around the world. Whenever people successfully negotiate their way through problems and find an acceptable compromise, an investment is made in social capital for the future.

Baum[9] concludes by saying that for the future, health promoters would need to:

- work out ways of assessing a community's capacity for social building
- discover how to develop creative partnerships
- use these as a mechanism to promote health and to challenge unhealthy developments.

The notion of social capital regarding the need to foster relationships and community cohesiveness chimes closely with the perceptions of the older Xhosa women. These women see relationships as the glue that feeds this cohesiveness.

The asset model

The second approach is related to assets that are embedded within communities and that determine health. The asset model stimulates a positive capability and joint identification of problems, as well as mutual activation of solutions. It thereby promotes the esteem of individuals and communities and leads to less dependency on professional services. This model further explains the persistence of inequities despite the increased efforts by governments globally to do something about them. Morgan and Ziglio[2] have explained that the asset model systematically gives an understanding of the causes and mechanisms of inequities in health and offers solutions for them.

The asset model for health suggests that health services should:

- make the best use of their resources to help reduce inequities by impacting the wider determinants of health to build stronger local economies, to safeguard the environment and to develop more cohesive communities

BOX 9.3: Health assets according to Morgan and Ziglio[2].

- Resources that individuals and communities have at their disposal, which protect against negative health outcomes. These assets can be social, financial, physical, environmental or human resources.
- Health assets are factors or resources that enhance the ability of individuals, groups and communities, populations, social systems, health and well-being, and help to reduce inequities.
- The asset can be at the level of the individual, group, community, social circumstances and environmental conditions, behavioural choices and health services.
- *At an individual level*: Social competence, resistance skills, commitment to learning, positive values, self-esteem and a sense of purpose.
- *Young people*: Protective factors that increase resilience to inhibit high-risk behaviour, substance abuse, violence and dropping out of school.
- *At the community level:* Family and friendship (support) networks, intergenerational solidarity, community cohesion, affinity of groups, religious tolerance and harmony – irrespective of being disadvantaged in the community.
- *Organisational and institutional level*: Environmental resources necessary for promoting physical, mental and social health; employment security and opportunities for voluntary services; political democracy; social justice; and enhancing equity.

Source: Morgan and Ziglio.[2, p. 18]

- consistently and coherently identify a range of protective and health-promoting factors that could act together to support health and well-being, as well as the policy options required to build and sustain these factors
- consistently promote the population as a co-producer of healthcare services, thus reducing the demand for scarce resources

- strengthen the capacity of individuals and communities to realise their potential for contributing towards health development as they are contributing towards life, and health is life.

To conclude the asset model, Morgan and Ziglio[2] make this comment:

> Though the asset model is less understood by those trained within the deficit medical model and hence there is little evidence-based research on this model, there is a need for a systematic approach to the asset model to create a more robust base and approach that will assist to demonstrate why investing in the assets of individuals, communities and organisations can help to decrease the health gap between those most disadvantaged in society and those who achieve the best health services. (p. 17)

In South Africa and Africa, 70%–80% of communities still follow a rural and pastoral lifestyle, whereby they draw from natural, indigenous resources for their livelihood and health needs. People in these communities depend on community collectivism to sustain themselves.[5,8,10] Drought, poverty and disease, such as HIV and AIDS, tend to draw people away from this self-sustaining environment towards the urban cities and a consequent dependency on money.[11] There is a danger of losing these assets if rural people are not, firstly, affirmed in how important these assets are, and, secondly, do not utilise these assets to develop rural communities and to enhance health.[5,8,10]

Horizontal learning and the recognition of prior knowledge

The third concept that the researcher would like to discuss is that of horizontal learning with its incumbent recognition of prior knowledge. This concept is integrally related to the *Ubuntu* of the African continent in general and to the Xhosa people in particular.

In the African tradition, an individual is born into a kinship group, with a network of relationships that involves mutual obligations (such as being a *Bomvana*) in terms of social, economic and religious factors.[11] This principle of *Ubuntu* with its

strong family structure and mutual support underpins African culture and is defined as follows[11]:

> The heritage of the philosophy that comes to us through our traditional African roots is *Ubuntu*: morality, compassion, care, understanding and empathy. It is one of sharing and hospitality, of honesty and humility. Simply put, it is the ethic and interaction that occurs in the extended family. In Africa, it draws in all people. In this 'family' there is a community of shared values and equality. (p. 25)

The community is the social interface where personal health and abilities, as well as illnesses and disabilities, are declared and are most apparent. Thus, the community becomes the point where health interventions can most effectively be directed and applied. Decentralisation of health services into the community and the integration of those members who are defined as ill and with disabilities into their society demands closer interaction with cultural factors and values. If PHC programmes within the African region are to be successful, they must be implemented by utilising some essential African cultural principles, such as *Ubuntu*. By far the most widespread resources are those already existing in the hands, hearts and minds of the African people.[12] It is important to acknowledge this and to utilise it in any implementation and the development of successful PHC and rehabilitation programmes, rather than harnessing communities into passiveness.[11,13]

A community 'resource analysis', identifying the potential resources from the community, particularly indigenous, along with the community's expressed needs, greatly improves the relevance and efficiency of PHC programmes. If PHC needs to have an impact on hundreds of thousands of people, then programmes must study, value, enlist and enhance these vital existing community resources. No plan should be approved unless some multiplication factors are drawn in, whereby a small input of knowledge and skills can bring into play a much larger amount of latent energy. We need to remember that people manage health problems day in and day out in every corner of Africa. We need to recognise the efforts of several million parents and family members who live with a moderately or

severely ill person, or a person with disabilities, coping with the situation, doing whatever they can, in living conditions that often make any special attention very difficult. The parents' or family members' efforts, and the efforts of those who are ill or with disabilities, should form the basis of any effective PHC programmes, projects and organisations. Primary healthcare should facilitate, strengthen and improve existing family and community efforts.[13]

Thus, the discussion on *Ubuntu* sheds much light on the model of horizontal peer learning. The Community Development Resource Association (CDRA)[8] asserts that transformation work that has been driving the (RDP) and PHC implementation in South Africa is challenging.[14,15,16,17,18] It warns transformers to proceed with caution and sensitivity. The CDRA mentions four guiding principles that underpin and influence the transformation of work:

1. *Transformation or development and the will or impulse to transform or develop is natural and innate*. Whatever state we find people in, they are always transforming. They may not be transforming healthily or they may be stuck here and there, but even after the transformers are gone, people will continue to transform. For example, in South Africa, the struggle for political freedom produced qualities and capabilities of leadership, a culture of humanity and self-belief, relationships of solidarity and much more, which have been used as the foundation for building a new country. This is the very opposite to what happened in Iraq and the war on terror galvanised by the president of the United States.
2. *Development is complex, unpredictable and characterised by crisis*. Developmental crises are burdened with opportunities for new movement and for qualitative shifts. Recognising and working with crisis, with all its unpredictability, becomes central to a developmental approach. Working realistically with human development requires an orientation that understands that a path is made by walking it.

3. *The next principle is related to people's own capacity to learn from experiences.* It is the foundation of their knowledge and development – we are what our experience has made us. Many, if not most, of our inner capacities and hindrances come from these experiences and how we have chosen to face them. Many developmental practitioners tend to ignore the enormous skills that people have gathered over time, including unconscious hindrances to development. For example, training a group of women in the rural Transkei to do project planning without appreciating and surfing and expanding on the skills that they have already developed, through the complex organisation of weddings, funerals and other community-related activities, is an outrageous waste of ingrained resources. It hovers on the edge of undermining and ignoring the existing knowledge. Thus, we learn from people who show us their experience and by connecting it to our own experience in a process known as *action learning*.
4. *The last principle is related to development as held in relationships*. We live, learn and develop within three different types of experience and relationships: Relationship with the self, interpersonal relationships with the people around us and external relationships with the rest of the world. Power is held in relationships, whether it is our struggle with ourselves to claim our inner power; the power we have over others; the power we hold with others; or the power that the state wields on its citizens. Without relationship, power means little; it has no force for good or bad. If we want to shift power, we have to shift relationships. It is within these three levels of relationship that people are deemed free or unfree. Elders in communities have vertical relationships with more junior community members. Elders have a more interesting role because their relationship with learners, and their context, is usually intimate and complex. As members of a community, they share many aspects of a peer relationship as insiders; however, they also bring with them story and history, local knowledge and wisdom, culture and tradition (both useful and not). When these are shared, they come not

> from outside but from deep within the community, from out of the past, revealing what already belongs to the community; it is heritage and deep identity.[2,5,10,19,20]

Community participation

The last approach to be discussed is that of developing meaningful partnerships with communities. This is another key PHC concept and principle. Boyce and Lysack[21] state that the origins of the modern notion of community are traced back to the European social philosophers of the late 18th century. These scholars noted that the growth of capitalism, industrialism and urbanisation altered the relationship between humans and society in a fundamental way. The result was a loss of interdependence that the four previous models have alluded to.[2,5,19,22,23] Since then, sociological research has attempted to categorise communities empirically, but with limited success. Currently, the term 'community' has two general meanings. Firstly, it refers to the social ideals of solidarity, sharing and consensus. Secondly, it relates to the actual grouping of people. This can facilitate an incentive for individuals to assume a shared set of interests, as physical proximity increases the likelihood of social interaction.

Cohen, cited in Boyce and Lysack,[21] suggests that there are two central ideas in a community. Firstly, there is an aggregational approach, which involves people with common interests, and secondly, there is the relational approach, which expresses that within the community one finds opposition and differences. This latter ideology contradicts any ideal notions of the community as being non-conflictual.

Boyce and Lysack[21] further defined community participation through a CBR approach:

> Community participation is the organisation of activities by groups of persons that are disadvantaged, in conjunction with others that are not affected (for example, health professionals), to increase their ability to influence social conditions, and in doing so to improve their disadvantaged situations. (p. 42)

Boyce and Lysack[21] further expanded on community participation and opined that community participation promotes goals, such as social justice, equity and democracy. They suggested that there are three purposes of community participation:

1. Participation can be a 'contribution' or a voluntary donation of people's resources to a common good or goal (participation as an instrumental means). This implies that community interests are cohesive and that internal, community conflicts can be resolved through democratic processes. This can be easily initiated in a top-down manner by authorities. As in PHC, barriers to participation can be commonly addressed by educational and motivational strategies.
2. Community participation as 'organisational' participation is the process of organising or arranging people in common activities (participation as a means to an end). Any barriers to participation are believed to be derived from operational problems and are usually addressed by technical and resource mobilisation strategies, such as lack of access that PHC has been preaching about.[7]
3. The last element is related to community participation as 'empowerment'. It is a more recent notion and implies both the development of management skills in local people and the ability to make decisions that affect their lives (participation as a transformational end). Empowerment assumes that people have a right to self-organisation and that internal conflicts between social groups can be resolved at the local level. Boyce and Lysack,[21] quoting Rifkin, maintain that the core concern is the issue of power: To address the issue of participation is to address the issue of power. This empowerment purpose of participation acknowledges the need for community members to exercise power and value social equity, which is achieved when this happens. The perception of the author of this book is that for PHC implementers to succeed, they would need to shift the health power from medical institutions to the very people they purport to serve and to their communities.[23]

The above frameworks assisted in the conceptualisation of how to approach the whole aspect of translation of the research findings. Affirmation of rigour of research findings and implementation strategies must take into account the specific context in which people live and the impact of local, social, cultural, economic and physical conditions and resources.[24,25] Implementation should address local concerns and use local resources, such as IHK. In addition, outcomes should be applicable and desirable for local communities and indigenous persons.[25,26] However, there is a paucity of knowledge regarding how to effectively implement intervention strategies that have been proven to prevent disease and promote health.[27] Studies on ways to effectively disseminate and implement findings in healthcare into practice are lacking.[28] This might partly explain why implementation of practices that have been shown to be effective by research is slow, especially at community and primary levels of healthcare.[3,28]

Currently, the efforts to translate and put findings into practice have often been uncoordinated, unsystematic and inadequately funded.[4,28] Implementing findings, including best-practice healthcare, especially related to the integration of IHK into the modern biomedicine within a transforming society, is imperative. Improved dissemination processes that are directly disseminated to all stakeholders, including communities and individuals, assist communities to work with researchers in creating strategies that will respond to findings, hence the community engagement approach that the translation of research findings intends to utilise.[4,22]

Drawing from the indigenous scholars in making meaning of translation of research outcomes

Drawing from the research findings of the PhD study, it became clear that the *AmaBomvana* are struggling with many social problems. During the dialogue, participants were struggling with

their reality, which the qualitative exploration had assisted them in unlocking, bringing these to the surface and facing these challenges. As the area was divided into four parts, using distances from Madwaleni Hospital, during feedback sessions each group was asked to contribute to solutions regarding the challenges they were facing. In the next section, some aspects of a way forward from each group are presented.

We need to go back home to revive our civilisation

The two groups located near to the hospital had a similar response. This is the group that has opted to pretend, having stopped using IHK, and has opted for Madwaleni Hospital to treat all ailments, including MHAs; however, they were also the group that was taking their relatives to indigenous healers on the quiet. Their response was that they need to go back home to revive their civilisation. It appeared that they were aware that there is a disjuncture between what was practised at the hospital and what was practised at home, and as they were struggling to cope with what was practised at the hospital, they were resorting to go back home to revive their IHK that was lying dormant in their homes. We found three possible opportunities through which knowledge lying dormant within the home could be revived:

- Using Early Childhood Development (ECD), we had a perception that the homes could be used as learning spaces for the children. Children could visit the homes to learn about the indigenous activities done in the home, including storytelling by an older person of the home. Using a reflective cycle, after the visit to the home, children could be facilitated to share what they had learnt from the visit. Stories could also be documented and a book of stories could be developed.
- Secondly, in households occupied by older people, we could use the list of herbs identified in Mji's study[1] and work with the

older women in identifying these herbs, photographing them and cataloguing them (this has already been achieved by the research assistant).
- The *Bomvana* also saw themselves as civilised warriors – we could also work with the homes in mapping up skills that are encased in the home that made them civilised warriors and then use the backward and forward movement in identifying skills that would still be relevant for future generations.

What has been achieved from this approach is to pilot visiting homes in ECD to learn about the activities of the home. This approach is still in its infancy to draw any conclusion from it. The aspect of affirmation of Mji's[1] list of herbs has been a success, with a catalogue of herbs of the principalities of this area having been compiled. The mapping of a skills project is also still in its infancy.

The backward and forward movement

The third community is an enclave of most of the indigenous leaders. The chieftain of this area, when asked what needed to happen, replied, 'we need a backward and a forward movement and check how our civilisation will be placed in the future and what it can contribute'.

We further asked the chieftain to explain to us, 'what does this movement imply?', to which he responded that when a new modern concept emerges, it needs to be weighed and compared with the old concept, and if the old concept seems to be the better concept we then move on with the old concept into the future, and if the new one is a better one, we leave behind the old one and adopt the new concept. As researchers, we were excited about this thinking. Coming from an in-depth understanding about the marginalisation of indigenous knowledge, unlike modern knowledge which had a platform for validation and for aspects that were not working to be weeded off, indigenous knowledge and its scholars have been excluded from the mainstream discussion on what works and what does not work. In this transformative strategy of backward and

forward movement, we saw that during and beyond the translation of the PhD findings, the strategy could be used to:

1. Dialogue with the community on what works and what does not work using the analogy of the chief with regard to what has brought ill-health in their communities in the areas of education, religion and health – what were the indigenous practices of the *Bomvana* prior to foreign entries and, within those practices, what works and what no longer works, and this would be the same for modern approaches in these three areas, so that at the end one comes up with a colourful blanket that combines both indigenous and modern knowledges.
2. We also believed that our interaction with the community should be underpinned and driven by this strategy, and what would be key in the weighing of these knowledges is for the community to decide what works and what does not work for them.

We have started this strategy in one principality using the space of *imbizos,* whereby we are engaging with the community to first bring to the surface attributes of being civilised, proud warriors. We also have started working with the indigenous healers, focussing more on the *amagqirha*, as this seems to be the group that is struggling most with the biomedical healthcare – where we are presently with this process is for the *amagqirha* to check their scope of practice and decide which aspects they are happy with and which ones raise some concern. Both approaches are still in their infancy. The goal for the *amagqirha* is to design a strategy on how they will work in tandem with the biomedical healthcare.

Our children, the educated ones, will assist us in reviving this knowledge

This aspect emerged during the feedback workshop of the fourth FG discussion, where the elite older Xhosa women expressed their anger that their indigenous knowledge was being ignored. When asked what they were going to do about it,

they said, 'our children, the educated ones, are going to assist us'. Our first step was to:

1. select postgraduate students to further explore some of the issues that were highlighted by the chief, which were related to education, religion and health, focussing on poor communication between healthcare providers and the community as well as the indigenous healers of Madwaleni
2. disseminate PhD findings in the secondary hospital, eight clinics and the Donald Wood Foundation by holding seminars with the key stakeholders of these areas
3. tabling of two conferences, with the second one being driven by the community (see Ch. 13).

Three PhD and one master's study emerged from these topics, of which one master's and two PhD students would graduate in April 2019. The findings have been disseminated in all the principalities of the area, including the health areas. The two conferences were a resounding success, and although the focus was on the elite older Xhosa women, this conference was dominated by traditional healers who hinted that they too would like to be part of a process whereby they can work together with biomedical healthcare services. The second conference was special, as it was driven by the community. A majority of the presentations were done by the community members. Some of the critical aspects that emerged from this conference were:

1. That the community can lead some of the activities that usually the academics lead – in this conference, both the coordination and presentations were led by the community.
2. Identification of indigenous community key role players: The children with their, singing, dancing and oration; the young adults with their singing; and the indigenous healers with their drum, singing and dancing – all these activities were unlocking an incredible positive energy, which started to create hope and faith for healing of this community that had its identity brutalised and distorted – a hope, first for reconciliation, followed by a possible unlocking of the potential of this community.

Gaining guidance from the key informants from the community and the research group from Cape Town

As the researcher was consolidating her research report and recommendations, it became clear that the area of social determinants of health is at the core of many of the problems that this community was struggling with. Because I started the research in Elliotdale, I have not severed my ties with the researchers from the Khayelitsha project on overcrowding of CHCs – we were further joined by other scholars interested in issues of IKSs. It also became clear that trying to quickly come from the top to work on issues of social determinants of health would duplicate the previous problems that this community experienced. The indigenous key informants suggested that we should engage with one community for a specific period. These key informants selected one community that they felt was a severely neglected community, and it was directly next to the Indian Ocean. This community is called the kwa Xanase.

Our approach to this community was to draw from the previous strategies already outlined. The systemic appreciative participatory approach will build on local strengths, with special attention to indigenous knowledge and community-based resources and practices. New knowledge and understanding will be generated through dialogue. New information and sustainable technologies will be introduced for exploration and experimentation. In this way, we aim to achieve an integrated system that combines both local knowledge and resources and the latest approaches to ecologically sustainable development. A continuous process of participatory decision-making through cycles of action and reflection will determine the direction of the project and provide the participatory evaluation mechanism that will include the community and the volunteer facilitation team.

The approach based on appreciative inquiry differs from the traditional participatory approaches in that it does not start

with problems. Instead, it asks about what is being done well in the community and in this way generates energy for change. Participants are invited to articulate their dreams for the future. These are then divided into those that require resources and help from outside the community and those that can be realised without help or resources from outside. In this way, the participants can identify actions that are like 'ripe fruit ready for picking' and are encouraged to start taking action immediately, as individuals or small groups, to start bringing about a positive change. These actions do not require consensus, but information must be recorded and pooled. At regular intervals, these small successes are acknowledged and celebrated, while the bigger dreams can be classified into smaller steps, and resources can be raised to begin to take on bigger actions. Our approach was to first develop relationships with this community. Our focus was on dialogue, starting with where the community was, which initially was about blaming the government to internally focus on inert strengths. Below are the steps we took in engaging with the community:

- Firstly, we approached and listened to the community to connect with where they were.
- Secondly, we focussed on dreaming and developing a picture of the future they desire.
- Thirdly, a step was taken for the identification of low-lying fruits and community assets.
- Fourthly, the community was required to select a group from them to coordinate the process.
- Fifthly, the *Imbizo* [chiefs' meeting] was used as a space to reflect on progress made and steps to take to revive the *Bomvana* culture and identity.
- Sixthly, we used ECD as a tool to unlock the knowledges of the home.
- Seventhly, we used the backward and forward movement as a strategy to combine indigenous with modernity.

What has already emerged from this community engagement is strategy:

- A community engagement strategy with community members driving this strategy.

- An ECD strategy with children attending school, facilitated by a local teacher and a committee supporting this strategy.
- A cultural centre with three rondavels built by the community.
- A conference organising group that can be further supported to improve their skills.
- A service account group that is thriving and ensuring that, despite the little they have, this can be multiplied by using community-based skills (Ch. 12 provides further reading about the Xanase savings group).

Research projects that have assisted in bringing funding to the area

Part of the focus of these projects was to translate PhD findings. Below is a list of some of these projects:

- The exploration of the indigenous knowledge of the elitist older Xhosa women of the Eastern Cape – funded by the NRF.
- The aim of this project is to disseminate and validate indigenous health research outcomes (IHROs) that emerged from a PhD study that explored IHK utilised by the older Xhosa women amongst the *Amabomvana* people in a rural research site in the Eastern Cape – funded by SUN.
- Rural community engagement and development project, Mbashe local municipality (LM) – funded by Diliza Mji and Moeleketsi Mbeki.

Concluding statement

Although the focus of this PhD study was initially on health problems managed by the older Xhosa women in their home situation, the older Xhosa women from KwaBomvane believe that there is a link between illness and the social determinants of health. They also believe that to achieve good quality of life and wellness, one must first address the social determinants of health. This approach to wellness appeared to be in conflict with the approach of the public health system in the study area. The research findings of the study also showed that the introduction of Western medicine resulted in the undermining and overlooking

of the IHK that was practised by the local communities. As the study progressed, it became apparent that addressing the social determinants of health was a priority for the challenges facing this community.

This rural community appears to be in transition, as they have lost belief in their own abilities to maintain their own rituals and activities that are linked to the social determinants of health. A long list of social determinants of health was mentioned by the older Xhosa women from this area. These social determinants of health that contribute to positive health indicators include having sufficient food, an adequate supply of clean water and sanitation, and the support from the indigenous extended family, including issues of spirituality. Bomvanaland, although appearing to be challenged with many social problems, also presents with a multitude of opportunities for engagement and moving forward in reversing some of the challenges the villages seem to be facing. According to Freire,[29] the concept of development reflects an understanding about the nature of power. Freire,[29] in his conception of social transformation, maintains that power in society is essentially structured on the basis of the class system. In terms of empowerment and community development, the powerless and the oppressed must appropriate themselves power, which hitherto has been in the possession of the powerful. Hence, by definition, only people can develop themselves. Yes, outsiders can play the role of being promoters and facilitators in the journey of social transformation and empowerment. As the secretary of the *Bomvana* group has discovered, civilisation starts from within.

Chapter 10

Bringing in a conversation in health and education: A missing link?

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Introduction

Using the *AmaBomvana*'s (an indigenous group in the Eastern Cape Province of South Africa) case material, this chapter explores and analyses the understanding of the relationship between the current formal education received by the *AmaBomvana* and their health and well-being. I do this analysis by drawing in the often silenced rural-based indigenous voices on how they link education and health and well-being in their communities. The voices of the *AmaBomvana* enable me to make

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meaning of what the *AmaBomvana* imply when they say that the introduction of formal education has brought ill-health to their communities. Locating indigenous people within the context of encounters with colonialists, I unpack the history of both the health and education status of the indigenous people. Through this reflecting and drawing on voices of the *AmaBomvana* accompanied by the existing literature, I firstly question the complex picture of indigenous health and demonstrate how it could also be linked to colonial education. Secondly, I suggest that it may be necessary to examine the education received by indigenous people as another alternative to addressing health and well-being.

The contributions made in this this chapter emanate from my doctoral study, which aimed to explore and describe, from the perspectives of the indigenous people, the potential relevance of indigenous knowledges in transforming the formal education system for better health and well-being. Discussions about education suggest that education has failed to ameliorate social ills in rural indigenous contexts; however, there is no existing literature in South Africa that has unpacked how poor education can contribute to ill-health and poor well-being. In particular, South African education is known to reproduce conditions, circumstances and environments that subsequently translate to social ills and poor well-being. In addition, South African formal education outcomes are characterised by the reinforcement of patterns of poverty and privilege, instead of challenging them.[1] Research about the contribution of education towards indigenous people's lives pays little or no attention to health and well-being as an indicator of a life-enhancing education received (or not) by the indigenous people.

This chapter emanates from my doctoral study that was built on outcomes of an earlier ethnographic study conducted by Mji.[2] Mji's[2] study analysed how indigenous people, known as the *AmaBomvana*, in the broader communities of Elliotdale in the Eastern Cape Province of South Africa manage their health using their indigenous ways of knowing and understanding health.

As revealed by Mji,[2] one of the perceptions of the *AmaBomvana* as they analysed their compromised health status was that the formal education introduced in their communities and received by their children has brought ill-health.[2] The first question, which came to my mind after coming across this perception was, 'how do the *AmaBomvana* see formal education as having brought ill-health into their communities?'

From Mji's[2] thesis, it was clear that in view of the colonial and apartheid history of South Africa, systems which both ensured that Africans continued receiving low levels of education and lived through migrant and slave labour, these perceptions of *AmaBomvana* at the time of democracy were worth exploring further. It was further important to explore and understand how this formal education is impacting the everyday living, doing and being of the *AmaBomvana* in view of the documented existing health disparities between indigenous people and the general population. The chapter will thus provide an analysis of Mji's[2] outcome on how the *AmaBomvana* are experiencing formal education in relation to their everyday living, doing and being, that is, their health and well-being. Drawing on the literature, I attempt to explain the complex picture painted by the *AmaBomvana* by making links between education and health. I conclude that more research bringing education and health in conversation is needed, to better understand the realities of indigenous people in more nuanced ways and to perhaps come up with a more effective health promotion and disease prevention strategies.

I will now ground this chapter by clarifying certain key concepts that inform the discussion.

Unpacking key concepts

The terms used in this chapter are highly contested. For the purposes of this chapter, the following definitions will apply.

When I speak about indigenous people, I speak about all formerly colonised Africans who have a close connection with

their ancestral lands,[3,4,5] following the saying that people are the land, and the land is the people.[4,6] I speak about the daughters and sons of the soil whose connections with the land signify not only a link between the physical and social environments but also a resource for collective and intergenerational living in land, as well as the significance of land to health and well-being.[3,7]

This chapter takes the view that health is the synthesis of, and/or the relationship between, doing well, being well or well-being, and becoming healthy through participating in meaningful activities in a natural environment.[2,8] It encompasses the spiritual, physical and social aspects of a person's well-being. Within an indigenous frame of reference, such conceptualisations of health also encapsulate that people, their communities, families and environments are intrinsically connected.[9] Essentially, all these aspects of health are interlinked, and it is a combination of these relationships that negatively or positively affects health and well-being of the indigenous people.[10] Mji's study further unpacks this understanding within the context of the *AmaBomvana*, stating that health includes a balance between living in peace, being happy, achieving food security in the villages, as well as being actively engaged in key activities and functions of their villages, such as bringing up children from childhood to adulthood.[2] These functions are perceived as contributing to doing, being and living well in indigenous communities, as well as influencing positive becoming. In these explanations, one sees how well-being is linked to the ability to fulfil cultural roles and participate in dignified and meaningful ways.

Using this holistic definition, this chapter looks at how education is perceived as contributing negatively to indigenous health. In particular, what and how do the *AmaBomvana* indicate the relationship between formal education to health and well-being?

A brief background on the doctoral study methodology

I integrated case study and narrative inquiries as methodological frameworks to facilitate a case of narratives with the *AmaBomvana*

in Xhora (Eastern Cape province, South Africa). The case study inquiry contextually bounded and situated the research study, while the narrative inquiry uncovered the stories that formed the basis of understanding the case in question. Indigenous methods (talking circles and storytelling using the sagacity approach) were used to collect narrative, primary data from older and younger people of the four sampled villages. Teachers were also engaged, but this chapter focusses on the primary data from the *AmaBomvana*. Reflexivity, reciprocity and continuous relationship building as aligned with the paradigmatic nature of the study grounded these methods. Ethical clearance was sought from the community leadership and from the ethics review committee of SUN. This chapter does not present raw findings of the case of narratives but presents an analysis of the existing literature that served as a rationale for the doctoral study.

History of health status of the colonised indigenous people

Although the health of the people from the different African regions has been the focus and a recurring topic internationally, indigenous people continue to receive very little attention.[11] This is despite evidence suggesting that indigenous people in Africa form part of the most vulnerable group, whose health continues to receive less importance from a public health perspective.[11,12] In South Africa specifically, the troubling past of colonial subjugation and apartheid dispossession has significantly and inexorably affected the health of the colonised indigenous people. Coovadia et al.[13] have earlier argued that this past carries the root of all the colliding epidemics of illness and disease in South Africa. Amongst others, racial and gender discrimination; the migrant labour system, which disintegrated many families; vast income inequalities; land dispossession; and extreme forms of violence all formed part of the pronounced effects on the health of the indigenous people. For instance, Coovadia et al.[13] referred to how indigenous people were violently conquered, while their lands and resources were appropriated. In addition, unjust laws

were used to forcefully make black people work for low wages to generate wealth for the white minority.

Before 1994, restriction policies ensured a hierarchical structure of the society by positioning the white people at the apex and the black people at the bottom as a normalised organisation of social life, which informed access to basic resources for health and health services. Within this arrangement, large racial differentials continued to exist in social determinants of health as the indigenous black people were subjected to marginalisation and discrimination and systematically experienced poorer health than the minority white people.[13,14,15,16] As such, the following four colliding epidemics occurred:

1. We experienced poverty-related illnesses such as infectious diseases, leading to maternal death, malnutrition, premature child mortality and disability-adjusted life years.
2. The burden of non-communicable diseases rose.
3. HIV and tuberculosis, chronic illness and mental health.
4. Injury and violence.[13,14,16]

Rooted in many distinct features of South African history, a series of events contributed to these epidemics and thus negatively influenced the health of the indigenous people. I will focus on a few historic events with regard to the health system challenges and the resultant burden of disease faced by contemporary South Africa.

For example, the introduction of cheap slave labour in farms and mines following the dispossession of land and cattle caused a complete shift within the country. This shift was a move from an agriculture-based economy to an imposed industry-based economy, following the discovery of gold in the Witwatersrand area in 1886 and diamonds in Kimberly in 1867.[13,14] As this mining became the cornerstone, the demand for cheap black male labour increased, and this demand was catered to by a colonial government intentionally creating a permanent workforce for the mining industry. Coovadia et al.[13] further revealed that ruthless methods, aided by legislature that coerced the migration of black

male labourers from other African countries and rural South African areas to the cities, were used to enforce this slave labour. This system greatly undermined the rural agricultural economy as more workforce was forcefully moved to towns, with women and children following later (although opportunities largely favoured men). This is a system of racial capital and white supremacy, which overwhelmingly provided whites with access to social power and control over material resources, including the land.

In this situation, families in rural areas were left struggling to make ends meet. Black people were not only exploited but found themselves in a situation where they had to guard cars that they did not own, clean homes and work in gardens that did not belong to them, take care of children who were not their own, and make and serve food that they could not afford back home. The migrant labourers were denied access to housing because of racial and spatial segregation, which led to overcrowded and unhygienic slums and hostels. This persistent spatial segregation resulted in the existing overcrowded townships and the massive violence, poor mobility, lack of services and other deprivations seen in rural areas.

These material and symbolic conditions subsequently led to disease patterns in South Africa and neighbouring countries that also sent migrants to South African mines. Tuberculosis started spreading as miners became too ill to be productive, considering the conditions they were working in, thus leading to a high turnover of slaves (which means that the slaves could not only be easily and forcefully collected but also easily and quickly exchanged for another when they became ill).[13] Family life of the black people was further undermined as this migrant labour increased. More homes were led either by only women or children or by extended family members in what was known as Bantustans. It is well-known that the scramble for Africa and the creation of colonial borders at the end of the 19th century, which persisted in the 20th century, split many families, including that of the indigenous people who were viewed as primitive and existing

outside the modern era.[17] This is aligned with what decolonial scholars critique as the modernity project to create one national identity, one state and one culture.[17,18,19,20]

Other events relate to the forceful imposition on the black people regarding where they were allowed or not allowed to live, work and school; whom to marry; and access to health, education and pensions. Similarly, laws were used to control these states of affairs. These events led to health challenges like maternal mortality, malnutrition, tuberculosis, HIV and AIDS, stress, poor diets and living conditions, which in turn led to several diseases and teenage pregnancies. It was only in 1994 that these epidemics were recognised as a quadruple burden of disease. In all these events, indigenous people were not only subjected to inhumane conditions but also to what decolonial scholars call epistemicide (the destruction of indigenous people's structures) and genocide (killing of populations of people through this quadruple burden of disease).[18,19,20] The life-threatening conditions, including the outbreak of diseases, were described as tantamount to genocide during the apartheid era.[16] Furthermore, these situations not only had devastating mental health effects on many African people because of feelings of hopelessness, desperation and family disruptions, given the rife migratory labour system, but also led to alcoholism, psychological disorders, personal violence and crime.[16] These effects have been reported as common in colonised contexts in view of the dispossession of lands and resources for livelihood.[11,21]

Despite the transformation after 1994, various studies have revealed a continuity of this quadruple burden of disease in South Africa.[22,23] In addition, the indigenous people remain the most vulnerable in terms of health status worldwide, bearing a disproportionate burden of poverty, disease, disability, and mortality compared to the general population.[11,24,25,26,27,28,29] A key but missing aspect in the above analysis of health status and the events that influenced it is that of the contribution of education. Where education is cited, it is only viewed from the lens of the low levels of literacy and a lack of formal educational attainment as

indicators and determinants of poor health. I argue here that part of the problem with this narrative of looking at the link between health and education relates to the exclusion of the voices of the indigenous people on how they are experiencing education that was introduced into their communities since the time of missionaries to the present. The dominant narrative that education is the key to success has, in a way, silenced questions related to which education actually leads to success in the context of the colonised indigenous people. It is for these reasons that it was worth exploring Mji's[2] outcome linking formal education received with decreased levels of health. Hence, as part of my doctoral studies, I further explored what this outcome could imply for the *AmaBomvana* as they experience this formal education. Could it be that we have not yet explored the in-depth causes of ill-health as perceived by the indigenous people? What then do the *AmaBomvana* imply when they say education has brought ill-health to their communities? How are the *AmaBomvana* understanding and linking health and education? This exploration helps in grounding the role of formal education in emancipating the indigenous people who have not only lost their lands but also their voices, dignity, culture and knowledges for better health and well-being.

Currently, the health system essentially consists of two subsystems: Private and public healthcare institutions. The private system offers services to the insured minority, those who can afford out-of-pocket costs, and is patronised by mostly white and Indian people. The public health system largely serves the black population through state-owned hospitals that are known to be dysfunctional and in a state of crisis. Despite the fact that public healthcare caters for the majority of the population, McIntyre et al.[30] and Chopra et al.[31] revealed that the private sector (which caters for a lesser population) consumes a larger budget. This arrangement has created not only a divide in the quality of care between the public and the private sectors, and a maldistribution between these two sectors, but also contributed to a maldistribution and inequalities between rural and urban areas and levels of care. Despite an increase in the budget and

expenditure, which targeted fair redistribution of resources within public healthcare, recent publications have shown that the challenges of maldistribution still exist, with the poor suffering the most.[32,33,34] The current majority of South Africans remain blighted with social inequities, which subsequently translate into what Scott et al.[23, p. 78] refer to as 'a high burden of premature mortality and marked health inequities'. These inequities continue to cause, maintain and reproduce the persistent quadruple burden of disease.

In between these two Western-oriented subsystems, there exists an indigenous (commonly known as traditional) healthcare system that continues to play a marginal role, with no equal footing with the public and private healthcare institutions. This is despite the fact that a large number of indigenous Africans continue to use this system of healthcare.[16,35] Although indigenous practitioners are now recognised in the *Traditional Health Practitioners Act* of 2007,[16,35] collaborations between this indigenous system and biomedicine remain fraught with unresolved power issues, mistrust and tensions,[35] thus operating on a superior–inferior logic of modernity. In other words, biomedicine is seen as scientific and superior, while indigenous healing is seen as backward, dangerous and unscientific. Biomedicine here acts as having overcome irrational beliefs. At the core of this issue, the indigenous ways of living and being remain subjugated.

Formal education and the indigenous people

African indigenous education is interwoven with, and forms the basis of, living. This education thus aims to prepare young people for responsibilities at home and in the community.[3,36,37,38] As such, every community member is a teacher at some point in his or her life, with education taking place every day and everywhere through everyday doing and living.[3,38,39] On the contrary, formal education is seen as distant from the daily experiences of learners

and prepares young people for work external to their communities through the capitalist system. During the colonial era, as Shizha[3] notes, the purpose of education was focussed on religious conversion, economic exploitation and forced assimilation of Africans. The entry into middle- and working-class life not only meant incurring a massive debt in an attempt to access basic needs but also left many indigenous people psychologically traumatised and mentally exhausted by the pressure to assimilate a white social culture and a forced modern way of living. The psychological effects of racism in a white world left many indigenous people feeling inadequate and dependent on the white people, which later led to forced assimilation and imitation. Ngugi wa Thiongo[40] previously observed:

> Education, far from giving people the confidence in their reality and capacities to overcome obstacles [...] tends to make them feel their inadequacies, their weakness and their incapacities in the face of reality; and their inability to do anything about the conditions governing their lives. (p. 56)

It was rooted in colonisation, because modern knowledge coming through formal education was located at the apex of the education system and was deemed as scientific, while indigenous knowledge remained on the margins and became known as unscientific, untested and barbaric.[3,41] This colonial matrix of power[42] explains the neglect afforded to indigenous knowledge in the education system. A colonial matrix of power is a:[13]

> [*P*]ower structure within which the social, political, economic, epistemic, psychological and physical experiences of the non-Western subject, among other aspects, are marginalized as they lie at the bottom of the hierarchically-organized modern world system. (p. 87)

This arrangement of the modern world thrived on the dominance of the hegemonic Western knowledge as universal knowledge over indigenous knowledge. Such colonisation is also responsible for the disruption of indigenous learning structures that forced the colonised to rely on the coloniser's learning structures and knowledges in the name of bringing civilisation, modernity and enlightenment.[17,37] What is important to note is that the coloniser

retained the power to define this civilisation, thus silencing the voices and choices of the indigenous people. This hierarchical arrangement can be traced in the South African education system.

For example, the *Bantu Education Act* of 1953 ensured that the white people enjoyed the brighter side of the modernity arrangement through receiving the best education compared to the black people who were only exposed to the darker side of modernity. Masemula[43] reported that the then prime minister, Hendrick Verwoerd, stated that the black people were only to be educated to be hewers of wood and drawers of water. Similarly, apartheid education, known as Christian National Education, only promoted values and knowledges of this dominant racial group.[44,45] This was a crucial agenda in maintaining the hegemonic element of apartheid education.[44,45,46,47] In this hegemonic system, the ruling class controls education, while Africans are socialised to negate their ways and willingly become accomplices of cultural imperialism. Shizha[3] stated that schools have become the vehicles for forcing this European civilisation and enlightenment, as well as the reproduction of this hegemonic knowledge. Apartheid education in South Africa drew people away from their communities and misguided them through instigating a desire for greener pastures of the European society on which they were not allowed to gaze.[48] Macaulay[49] added that the aim was to completely wipe out the identity and history of the colonised. This de-rooted and alienated Africans from their reality.

Although the transition to democracy in 1994 came with many changes, such as the White Paper on Education and Training[50] and the National Curriculum Statements (NCS),[51] which aimed to transform the education system, the power dynamics between knowledges was still seen in policy implementation. As such, indigenous knowledge still remains trapped in the colonial matrices of power with no willingness to present and apply that into practice, as echoed by various scholars.[52,53,54,55,56] Following these challenges, the South African IKS policy of 2004 was thus formulated by the Department of Science and Technology to provide an implementation framework that could be used for all

subjects to value IKS.[43] However, this idea remains a symbolic one partly because of the global matrices of power which we have not been rescued from.[41] Despite IHK's recognition in various education and related policies, various scholars[57,58,59] still argue that indigenous people's sense of the world in South Africa continues to endure a marginal role in the country's education system. Again, this is a clear reflection of the presence of matrices of power and knowledge, which entertain, as Green[60] posits, the dualism between IHK as the primitive, unscientific and irrational knowledge and Western knowledge as having overcome mythical and irrational beliefs. This hegemony remains challenging and powerful in the South African education received by indigenous people, and the picture is troubling and complex.

Despite the fact that good education starts from where people are and is aligned to how people live,[2,61] schools continue to position themselves at the apex as the only repositories of knowledge, while learners are treated as coming with no prior knowledge. This issue is worse in rural contexts as curricula remain urban biased in addition to being modernity biased. Learners in rural areas thus face daily pressure from the conscious and unconscious notions of white supremacy through the curricula and media (white people and their culture are better, and urban life is better than rural life). These notions prompt learners to think of urban areas as better dwelling places, while instilling feelings of hate towards their rural backgrounds and ways of living.[6] This desire serves to support racial capital and means of production. These oppressive ideological forces not only influence the constructions of reality but also serve to alienate children from their sociocultural contexts, as they learn to see them as backward. They push for assimilation and imitation, internalisation of whiteness values and an alienation from the self. In classroom spaces, these processes disempower indigenous learners into submissiveness in this social order. What manifests is best described by Ndlovu-Gatsheni[17,62] as a crisis of identity and a restrictive, programmed thinking which is only based on textbook learning.

Ndlovu-Gatsheni[62] adds that this arrangement tames people into unquestioning acceptance of things and locking any ability to actively act and challenge forces that are marginalising. It is unsurprising that what would result, therefore, is what Ramugondo[63] refers to as a coloniality of doing. Instead of challenging the dominant hegemonic ways of doing and thinking, a coloniality of doing is where people mimic and appropriate while they are subsequently restricted from thinking from where they are.[62,64] They are taught that all they know from home has no value; they are taught to hate themselves and their environments; they are taught that it is primitive to be, do and live according to the ways they have been taught at home; they are taught to assimilate.[6] Surely, this has psychological effects. These challenges not only hinder good performance and achievement in school but also translate to everyday doing and living challenges. Hence, the *AmaBomvana* are saying that the introduction of formal education has brought ill-health in their communities.

Readings of such an education system conclude regarding various implications in terms of everyday being, doing and becoming of indigenous learners, namely:

- A sense of disconnection and dissonance in the everyday lives of the learners.[65,66,67]
- This experience often leads to what Shava[52, p. 122] calls a 'dualistic divide between what indigenous students learn at school and what they learn in their communities and lived environments'. These dominant knowledges shape indigenous people's lives by normalising construction of new identities that run contrary to the indigenous cultures and value systems, resulting in an alienation of learners from their own sociocultural origins and no sense of autonomy.[27,68]
- Disjuncture in socialisation values.[69]
- A journey of alienation from their own African contexts and a painful path of learning to hate themselves and see their own ancestors as demons.[62]
- Unsustained learner interest and discomfort, which cause dropping out.[70]

- '[*T*]he education system generally produces outcomes that reinforce current patterns of poverty and privilege instead of challenging them. Unsurprisingly, we find that the inequalities in schooling outcomes manifest via labour market outcomes, perpetuating current patterns of income inequality'.[1, p. 3]

The above conclusions are indicative of an education system that is failing to transform and enhance people's lives, particularly that of the indigenous people, in view of the huge gaps between the haves and the have-nots. They also demonstrate a failure of this education system to challenge the hierarchical white supremacist social structures that support and reinforce this troubling picture. I will now examine this education system and the health status of the indigenous people based on the given evidence.

A troubling education system, a troubling health status of the indigenous people: What is the link?

Mji's[2] study revealed that the perception that education has brought ill-health to the communities of the *AmaBomvana* is informed by a witnessed clash of values between formal schooling and indigenous education. This clash in socialisation values is a recurring topic when reporting about the South African education system, as discussed above. The *AmaBomvana* are, therefore, raising profound statements and critical questions as they search for the meaning of education in their everyday living. In addition, they are raising profound questions related to the purpose and relevance of formal education. These questions are at the core of indigenisation and decoloniality calls for curriculum. If we look at Mji's[2] study critically, the following issues are raised by the *AmaBomvana*:

Firstly, the *AmaBomvana* perceive that formal education is neither drawing on their local knowledges nor focussing on learning activities that either affirm or build on the existing knowledges produced within their homes. The first issue talks

about a coloniality of power and knowledge. It is well documented that the hegemonic dominance of Western knowledge systems, as well as an unwillingness to represent and apply local knowledge systems, is common in (de)colonised Africa.[52,54,55,56] This is the picture in South Africa. Indigenous knowledge remains unrescued from the coloniality of power and knowledge despite evidence indicating that this hierarchical order of knowledge leads to issues of concern for the indigenous people. There is a notion that not only are the white people better than the rest but also that Western knowledges and their cultures are better than the rest. This also speaks about an education system that fails to recognise indigenous people as thinkers and knowers who possess valid knowledge systems. The psychological effects here present people who do not truly understand themselves because their knowledge, which informs their being, is seen as backward. They become divided between their indigeneity and the cultural codes of the coloniser and are forced to imitate and appropriate. They enter a journey of not only cultural but also a psychological dislocation, which was earlier pronounced by Fanon. The devastating mental health effects arising from this condition may be responsible for the increased alcoholism, psychological disorders, personal violence and crime, all of which contribute to the burden of disease in South Africa. The escape from this condition not only ends with mimicking but also overindulging in alcohol and other substances as some form of an analgesic for the pain induced by cultural dislocation.

Secondly, and linked to the above issue, the *AmaBomvana* are of the opinion that this education neither prepares their children for a life in their communities nor instils a sense of social responsibility. Owing to a coloniality of being, if people in these struggling and subjugated rural areas are not away for migrant labour, they are occupying taverns, exposed to alcohol and other substances daily, thus neglecting participation in facilitating progress in their communities. In many indigenous communities, learning is always linked to the survival of the community or family, implying that it happens through active participation in

the community. What is highlighted here is the crucial aspect of learning through doing. On the contrary, they see formal education as a means of introducing a sense of competition as well as divisions informed by class. As Kisanji[38] argued, these widening gaps threaten both the moral and the economic responsibilities of all members of society. These divisions are also evident amongst families and clans, as most older people have no formal education and are thus undermined by the younger people. This results from an education system that is classist in nature. The values of reciprocal respect (the young respecting the old and the old respecting the young), collective ways of living and intergenerational interactions, which are seemingly being eroded,[2,6] are key indicators of living and being well in these communities, as Mji's[2] study has revealed. As a result, both Mji[2] and Ned[6] revealed that young people are perceived by older people as no longer interested in the communal learning structures that encourage learning through doing. Yet, this learning through doing not only assists these children in acquiring skills important for what Nyerere[71] referred to as self-reliance later in life but also is an important strategy that makes learning contribute meaningfully to sustain indigenous homes. It is clear here that the doing-orientedness of education in indigenous homes was meant for survival, and enhancement, of the home, whereas the migrant labour job-orientedness of school education is meant for work in a capitalistic society, whereby the minority conquered labour for the benefit of those who control the resources.[6] In other words, in this capitalistic economic arrangement, the labourers' homes suffer as they are neglected with children left to raise other children (child-headed households) or at times women left to mend the home as a single parent. These living conditions contribute to a negative health status in the sense that they compromise the home, its activities and the upbringing of children. While many move for migrant labour, key activities such as producing food (identified as key to health) are neglected. As described previously, many indigenous people plough, harvest, prepare and serve food that they cannot take to their own homes and families. For instance, Scott et al.[23] reported

how increased cases of obesity, which is a significant factor in lifestyle diseases, are linked to who controls the land and food production. As expected, those with no land find it difficult to access good-quality food for their families, as they occupy the bottom of the chain, earning just enough to access processed foods with high fatty acids and genetically modified organisms (GMO). I argue that an education that is not interested in enhancing people's lives and which does not contribute to food sustenance of indigenous homes has negative implications for indigenous people (and being well); hence, the third concern is raised.

Thirdly, the *AmaBomvana* are of the perception that formal education is thus alienating their children from their villages. Ndlovu-Gatsheni[17,62] explains this well by stating that children are taught to hate their ways of being and living, resulting in a deep sense of alienation from themselves and being de-rooted from their environments and ancestors. This was expressed as a huge concern given that development of their children through education seems not to be contributing to the development of their villages – this being a crucial indicator of living well in these indigenous communities.[2] It is widely understood that being isolated from aspects of your identity has a negative effect on indigenous health.[27,72] These alienating structural and systemic factors of formal education are responsible not only for disrupting indigenous ways of knowing but also the doing and being well, which all make up indigenous health.[73] Durie et al.[73] argue that both access to culture and heritage, as well as an ability to express and endorse this culture in society's institutions and practices, make up positive indigenous cultural identities. This means that when indigenous people are denied opportunities for cultural expression and endorsement, they are more likely to experience hostility, which often gives rise to explosive behaviour, such as violence and injury and alcohol consumption, which contributes significantly to the burden of disease and disability.[27] The question that remains is, 'why is the education system not contributing to reclaiming healthy identities that are not characterised by a

burden of disease, poverty and disability?' In other words, 'why is the education system doing the opposite, that is, reproducing patterns of poverty and privilege, as argued by van der Berg et al.?'[1] Doing such would break down the white supremacist and racial capital systems of power, which thrive on enslaving and exploiting the colonised. Capitalism requires inequality and uneven development to make it possible to think that it is normal for one small group to take all the wages.

Van der Berg and co-authors[1] add that these patterns can be seen in various socio-economic indicators, such as education, which is commonly cited in this context as causing poor health. As Reading and Wien[74] write, these inequalities serve to restrict indigenous individuals, communities and nations from accessing resources that may ameliorate problems caused by the capitalist system. An example of this, for this chapter, is how the reproduction of inequality by the education system produces circumstances and environments that in turn reproduce subsequent negative determinants of health. The importance of questioning the role of education in health promotion is explicit. Poor education leads to negative identities, which in turn translate into negative or risky health behaviours and diminished opportunities to actively engage in communities, live and do well, thus further aggravating poverty.[75,76,77,78,79]

Poor education in this context speaks directly about the intersection of the three concerns raised by the *AmaBomvana* in Mji's[2] study. Denied their indigeneity and material resources, they are prevented from actively participating in key activities such as producing food and raising children to adulthood. Feelings of alienation, dependency, hopelessness and inferiority manifest, and when this happens, Ramugondo's[63] notion of a coloniality of doing is initiated. This is to say, the alienation that the children of the *AmaBomvana* experience as a result of poor education involves consequences such as a denial of self (compromised being), not participating in activities that reclaim the invisibilised knowing and thinking, and participating in other activities that do not necessarily align with their indigeneity. As such, new

identities are similarly developed, and these clash with the indigenous identity. This assertion affirms King et al.'s[25] and Siedman's[68] earlier work, in which they state that dominant knowledges shape indigenous people's lives by reshaping the construction of new identities that oppose the indigenous cultures and values. What results is an alienation from one's own sociocultural origins and no sense of autonomy and choice about everyday living and doing. If education is failing to liberate people from such a complex struggle, it may be the case that this colonial education indeed has negative implications for the health and the well-being of the indigenous people.[6]

Implications for research and education

When we begin to read colonialism from and within our realities or from the way we have experienced it, we are able to see its darker side. Firstly, there is a need to continue critiquing the dominant Eurocentric academic model, which supports epistemic coloniality. Therefore, more questioning research is needed to grow evidence of the negative outcomes associated with colonisation, assimilation and forced removals of people from their lands on indigenous health. Secondly, we also need to begin a journey of imagining alternative models as part of a decolonial agenda. Much more work needs to be done here. But this cannot be successfully done without a profound understanding of the situation we find ourselves in today. Therefore, the former and the latter implications here should go together if we are to better rethink a formal education for tomorrow. More specifically on education, more research is needed on how education can effectively enhance people's lives (i.e. contribute to living well amongst indigenous groups). Furthermore, a particular focus on developing schools that invest in health promotion is critical.

The analysis of the *AmaBomvana* is a clear contribution to knowledge production. Ontologically and epistemologically, we have a history of urban bias and an orientation, which denies

rural areas, specifically the rural indigenous people, their rightful place in knowledge production contributions. The history of research is guilty of this position, and it is here that knowledge hegemonies and injustices prevail. The link raised by the *AmaBomvana* not only brings attention to a missing layer in the discussion of health inequities but could also potentially contribute to transforming the academy to better service the lives of the indigenous people.

Concluding statement

This analysis provided a foundation for questioning the purpose of education in the context of the (ex)colonised in view of the fact that the majority of the indigenous people are characterised by poverty, disease and disability. The colonial matrices of power, knowledge, being and doing intersect to reshape the realities of the indigenous people. It is clear that any education that denies people their local agency may barely resemble anything related to the lived experience of the indigenous people. It is also clear that such an education reshapes experiences of being and living well in this indigenous community. As such, education continues to be a source of alienation and dependency instead of liberating people to disrupt oppressive systems and enhance their lives. Ultimately, over time, the feelings of alienation lead many to be completely de-rooted from themselves and their environments. This de-rooting may translate into negative health indicators and social ills that undermine contextually relevant progress in these communities. Similarly, such a poor health status may negatively influence learning and doing well later in life. If attention is not paid to education, we may be slow in improving health outcomes of the indigenous people. It is for this reason that more research that brings in conversations on health and education is needed, to better understand the realities of the indigenous people as shaped by a formal education that is colonial in its nature and form. This may be a process towards reclaiming the positive identities of the indigenous people and their knowledge as valid.

Chapter 11

Indigenous spirituality within formal health care practice

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To exclude spirituality is to ignore an important source of healing for many.[1, p. 189]

Background

This chapter emanates from my doctoral study, which aimed to explore understandings and interpretations of spirituality within the South African context that influences well-being. This has implications for well-being and optimum development within African indigenous communities. In this chapter, various understandings and interpretations of spirituality will be discussed, with a focus on accounting for the relevance of

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positioning African understandings of spirituality within contemporary discourses and how these understandings could interface with external knowledge systems to influence health and well-being within African indigenous communities. The tenets of African indigenous spirituality embed within it the socio-economic, cultural, health and political systems within indigenous African communities; hence, it is a crucial and integral factor within these communities. I discuss the PHC approach within South Africa, arguing for the relevance of positing African indigenous spirituality as an ally, and enabler, of PHC. I further suggest how current understandings of African indigenous spirituality could inform formal healthcare practices and policies within African indigenous communities.

Global perspectives on spirituality

To gain a wholesome understanding of spirituality, there is a need to explore how spirituality as a term and as a concept began to form and emerge historically. 'Spirituality' as a concept emanated from the Latin word *spirit*, which means 'breathe'. Early writings on spirituality were mainly influenced by Christian Western understanding,[2,3,4,5] which contributed to a narrower understanding of the term 'spirituality'. It is relevant to begin to explore other understandings and conceptualisations of spirituality existing within various cultures and contexts. The notion of spirituality itself, as a phenomenon, is not constricted, confined or narrowly defined. Therefore, experiencing spirituality from one point of view seems quite redundant.

Academic literature on spirituality dates back to the 1960s and continued to grow as the concept of spirituality drew more interest within various disciplines. Two reasons given for the amount of interest shown regarding spirituality in academia has been ascribed to the lack of total faith and reliance on knowledge seen as 'scientific', because this knowledge has fallen short of expectations. The second reason is linked to the fact that people

are beginning to feel a sense of disconnect within society and seek a sense of belonging.[5,6,7] This is especially related to healthcare with its perceived impersonal nature. The increased interest has also heralded the need to further unpack, define and understand the phenomenon of spirituality in order to shed more light on it.

However, defining spirituality has been problematic. Spirituality is operationalised within a holistic framework that seeks for an awareness of the self and others, aligning to issues of social justice and ethics, meaning-making, moral values and philosophies, and seeking to help create an egalitarian society to the benefit of all.[8,9,10,11] Its transient nature means that it is never in a permanent state, but its understanding keeps shifting according to context and engagement. Certain scholars posit that it would be erroneous to try and define spirituality. They argue that applying a definition would mean seeking to categorise and separate various aspects of spirituality from each other, which goes against the holistic nature of spirituality.[12,13] Defining spirituality, these scholars insist would reduce the wholeness of the concept. Despite this assertion, certain attributes can be identified across various definitions of spirituality within literature, which begins to open up a space for a common understanding of spirituality, as will be discussed further on in this chapter.

Spirituality and religion are perceived to be one and the same thing within certain bodies of literature, while other schools of thought separate the two concepts. The definition of religion is more in line with structural rituals and belief systems about a deity or higher power, as inclusive of beliefs, practices and rituals that are linked to the divine.[14,15] Religion is perceived to be an expression of spirituality.[5] One cannot be religious without some acknowledgement of ones' spirituality; however, a person can be spiritual without being religious. This is based on the argument that, unlike religion, spirituality does not necessarily have to involve a supreme being, deity or other divinity.

Spirituality, on the other hand, has been perceived as an individualistic, or collective, search for meaning in life, as a personal (and/or collective) motivator, a way of being.[5,10] Spirituality, on the other hand, could be experienced without any affiliation to religion and particular practices. Spirituality is also conceptualised as positive human values that include low life conflict and self-discipline, peace and harmony, life satisfaction, fulfilment and well-being.[16] These core human values are critical aspects that inform the social determinants of health and well-being for the indigenous communities.[17]

I have grouped two main understandings of spirituality that emanate from literature into individualistic and collective understandings of spirituality. The more individualistic understanding perceives spirituality as a personal, private individual experience[18] of self-actualisation or greater knowledge and awareness of self[19] and a personal search for peace, harmony and meaning in life.[5] Collective spirituality can be explained as a connection to self, other people, nature and a higher being.[3,14] This is the prevalent understanding of spirituality within indigenous communities around the world.[11,20]

I, however, would like to add a third dimension of spiritual understanding to the two points already given above. I would posit the individual within the collective as another way of understanding spirituality.[21] This is explained by the fact that whichever way spirituality is understood, the elements of spirituality include the search for meaning and purpose in life, inner strength, self-transcendence and belief. It also includes connectedness to something outside of oneself, a reach beyond oneself; this speaks to the collective. Within the ideology of an Africa-centred psychology, one can only know oneself after achieving intimacy and a sense of interconnectedness, seeing oneself as a part of the whole. There is no separation of the spiritual and the circular. People are individually taught to respect and practice their spiritual belief system within their families as they grow up, and then they are expected to uphold and guard

these tenets as part of the collective.[22] This belief of grounding the individual within the collective forms the basis of the *Bomvana* spiritual practices that ensure well-being. Thus, this understanding is critical to healthcare practice within these communities.

Because of the fact that the people whose narratives form a part of this chapter perceive no difference between spirituality and religion, I will also posit spirituality and religion as similar, using both terms interchangeably in this chapter. The understanding of spirituality I use here also aligns to the worldview of the study participants. Thus, I define spirituality as consisting of relational aspects or connectedness, which essentially exists as a process, representing growth, or a journey. This capacity, consciousness and connectedness provide the motivating drive for living, and constitute the source from which meaning and purpose is derived.[15] It influences all aspects of life as evidenced within the study context.

Methodology

A qualitative interpretive methodology was deemed appropriate and utilised for this study. It was chosen for the study because the qualitative paradigm explores and seeks to understand the meaning participants make of an issue or phenomena. It also explores the nature of reality as a social construction.[23] The qualitative study is an interpretative, naturalistic approach in which phenomena are studied within their natural context, also situating the researcher within the study context,[24] which made it appropriate for this study. Within the qualitative inquiry, the case study is utilised.

An exploratory ethnographic case study approach was chosen for this study because it equally allows for the study of a phenomenon of interest within its context. A case study approach is defined as a 'systematic and in-depth investigation of a particular instance in its context in order to generate

knowledge'.[25, p. 4] This study design allowed for multiple data collection methods, supporting a flexible, holistic approach that suited the phenomenon this study is focussed on.

The theoretical underpinnings of the study emanated from the resilience theory,[9] while the second framework is *Ubuntu,* which is an African philosophical framework.[26,27] Social justice theories are concerned with social justice issues, seeking to bring about change, non-violence and universal human rights.[9]

Spirituality is identified within resilience theory, and also within this study, as extremely important to community healing and well-being. Literature on resilience theory has focussed on certain areas as key to discussing the spiritual dimension and its ability to influence positive outcomes and promote health and well-being. Seven main areas were identified, and in this context, spirituality acts as a source of resilience, namely, close relationships, social support, moral conduct, personal growth, adaptive coping and development of meaning and purpose in life.[28] These seven areas will be discussed in terms of implementing PHC within the *Bomvana* communities.

Bomvana context and spirituality

The study is situated within four *Bomvana* village clusters (Hobeni, Madwaleni, Nkanya and Xhora) and is informed by one outcome[29] study. The *Bomvana* people identified spirituality as one of the areas where their cultural continuity has been disrupted, causing a loss of well-being for their community.

As with other *amaXhosa*, the *Bomvana* spirituality is very tribal and primarily focussed on ancestral veneration. There has been some vagueness about whether the *amaXhosa* believe in a supreme being or not.[29] This study makes it clear that the *AmaBomvana* recognise the presence of a supreme being. It is believed that the *Bomvana* names given to God were borrowed from various tribes and certain external influences they met

during the Xhosa migration, and as new entries arrived within their context.[29] The most generally used term to describe the supreme being by missionaries who worked in Bomvanaland was *u-Thixo*.

Various traditional rituals and sacrifices are performed to establish and maintain relationships that support well-being. This is because the *Bomvana* perceive well-being to be about healthy balanced relationships with the living and the non-living. This I refer to as a three-dimensional spiritual relationship that involves people, nature and divinity.[30] The divinity is believed to infuse life and wholeness into the physical, social, environmental and spiritual well-being of the community.[31] One example of this spiritual relationship and its impact on well-being is seen in the not so recently practised ritual of *uku-ruma*, where a traveller throws something valuable, such as a piece of jewellery, into the river for the spirits of the river to allow them safe passage.[29] Consequences arise from not performing certain sacrificial obligations, which is believed to affect the community as a whole.[29,32,33]

The *Bomvana* live under the rule of *amasiko* [the tribal customs], which are the principles that guide the interaction between the *Bomvana* and their ancestors.[29] Conformity with this expectation is the foundation of the *Bomvana* moral–religious codes. *Amasiko* refers to long-standing customs that have existed and will continue to exist. These customs and traditions have been put in place by their ancestors and cannot be undone. The spirituality of the *Bomvana* is regarded as life, health and living to them, and is practised by individuals but frequently expressed and experienced as a group.[34] This understanding of a collective spirituality has been a challenge for formal healthcare practices within indigenous communities. These challenges continue despite ongoing policies that identify the relevance of practising healthcare within an approach that supports contextually relevant and culturally congruent care. An example is the PHC approach within the South African healthcare system.

Primary healthcare approach in South Africa and its implications for the area of spirituality

> Primary Health Care is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible 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.[35, para. 1]

Research from various parts of the world reveals the connection between adequately provided PHC services and self-reported health outcomes.[35] Primary healthcare takes cognisance of issues of income distribution, culture, context, affordance and other social determinants of health and their impact on the health and well-being of individuals and communities. Primary healthcare seeks to address health disparities across populations. Reports in a study conducted in the United States revealed that the capacity to access good PC nullified the impact of health disparities brought on by income disparities.[36]

Primary healthcare in South Africa is envisaged as an approach of 'health for all'. The PHC approach within South Africa began in rural KwaZulu-Natal through the Pholela Health Centre model in 1940. This was the model of healthcare which was to inform all healthcare practices in South Africa, providing appropriate healthcare services, especially for the disenfranchised rural communities in South Africa. The Pholela Health Centre was innovative, integrating preventive, promotive and curative care, focussed more on communities than individuals. The Pholela Heath Centre was about holistic care, addressing the social determinants of care and not just simply medical care.[36,37] One very significant approach of the Pholela Health Centre was that the services provided were informed by the community or the local population it served. Hence, understanding of care was derived from the community and care was tailored to the specific

needs of that community. Community members were involved in planning, decision-making and delivery of healthcare services within their context.[37] Individual-, family- and community-level interventions that consider particular contexts and experiences of the target population is a hallmark of PHC. The Gluckman Report of 1944, which followed soon after, recommended a reorganisation of South Africa's health systems according to needs and not means. This new health system would provide comprehensive care and emerge from an adaptation of the Pholela health model, with numerous PHC centres providing integrated healthcare delivery at the primary level.[37]

Despite the core aim of PHC being to address healthcare inequities through the practice of holistic care, disease prevention, especially within low-resource communities in South Africa, is frequently overshadowed by the strong focus on incidence and prevalence of diseases.[38] This occurs even in the face of an appalling disparity amongst populations related to challenges that impact on the social determinants of health. Ned et al.[38] argue that the current manner of healthcare practice sees people as passive recipients, negating the beliefs and ability of populations to contribute valuable information and partner effectively with healthcare practitioners to achieve their health outcomes.

Medical pluralism is still very much a reality within the South African context, especially related to mental healthcare.[39] Diviners, herbalists and faith healers provide culturally congruent care within the South African context; they are accessed by and reach more black South Africans than Western healthcare does. Traditional healers are considered the first point of call within the community.[39] These facts, although noted, have for the most part been ignored with healthcare planning and not made distinct with the implementation of PHC.[32] Ignoring this fact will not make it disappear or its impact less felt by those who avail themselves of these 'alternative' practices. This indicates the need for a shift in healthcare practice that is sustainable. Primary healthcare is

aligned to sustainable healthcare outcomes at the grassroots level for populations, which addresses inequities within the system, utilising a bottom-up approach to elicit and encourage the participation and partnership of people who access these healthcare services. Understanding and taking cognisance of the various beliefs that exist within populations in terms of their well-being is important and has implications for healthcare delivery,[40] as advocated within PHC.

Despite these lofty aims, access to PHC for indigenous communities has been challenging because of their unique history of marginalisation and racism.[41] To these factors, I would like to add the exclusion of indigenous eco-spiritual practices that inform well-being for these communities. The implementation of these ideals within PHC has been problematic when it comes to African indigenous practices and belief systems,[42] especially its spiritual healing system. A study was carried out in 2014 to identify how successful PHC implementation has been within rural South Africa.[43] The study outcomes identified health promotion, prevention, attitudes of healthcare professionals and a lack of patient-centred care, amongst many other factors, as challenges to PHC implementation within rural South African communities. Even within the context of this study, various attempts have been made to separate indigenous spirituality from indigenous pharmacology by the healthcare system, with healthcare professionals preferring to work with medicine men rather than *Sangomas*.[44] However, I argue that the very embedded and holistic nature of indigenous spirituality is where its strength and unique contribution to PHC is derived from. Understanding spirituality as an integral part of health and well-being within these communities will aid more sustainable healthcare practices in various ways.

Discussion

Modernity has undeniably brought about many benefits to humanity in relation to scientific and technological advancement,

which is especially evidenced within the practice of Western healthcare. However, the fact that modernity has not fulfilled all its promises and we still exist in a world with unrivalled inequalities, wars and injustices that are consistently perpetrated against certain populations has facilitated a push for something more. This need for more is about connecting to something greater than we are, which is sorely needed in the current state of our world.[45]

Primary healthcare is population driven, identifying contextual supports that can aid its implementation, deriving meaning from its context. There is a need to recognise the role of culture and spirituality in the well-being of indigenous communities, and begin to implement care in a manner that reflects these concepts. It is implicit that cultural diversities and ethno-histories[46] should be considered in the implementation of PHC. Within healthcare, this is aimed at providing culturally congruent, safe and meaningful care to people. As stated earlier on in the discussion, a discussion of indigenous people's state of health without identifying and highlighting the social determinants around them and how this impacts on their experience of well-being would be fallacious.[47]

The *Bomvana* people practice an ecological well-being that is inclusive of every aspect of their context and lived experience. Hence, when restrictions are placed on their access to certain natural resources, their health is impacted, and it becomes an issue of social and environmental justice.[48] Spiritual principles are integral to the achievement of social justice,[49] and there is a call for the use of spirituality-based practices to inform frameworks of social justice engagement. One can safely say that the achievement of sustainable development outside of an equal society where every belief system and culture is respected will be a serious challenge. Spirituality and cultures are interwoven, and culture care builds resilience.[50] Culture provides an understanding of positive difference, so that an indigenous community's belief system is not demonised because of its difference from the point of view of other dominant belief systems, and this negative

stereotype becomes the established norm of perceiving that indigenous culture. Rather, culture is a resource that creates a space for collective meaning-making, which contributes to well-being.[51]

The main barrier to finding some synergy is a mind shift in the understanding of indigenous spirituality and its negative stereotypical representation within healthcare practice. This impunity is not only bequeathed to indigenous spirituality but also to other concepts that are linked or integral to its practice. Thus, the first hurdle to potential collaboration is the perceived lack of dependability of oral tradition, because narration of oral tradition might be influenced by the motives of the narrators. However, the fact that most oral traditions are produced in a place of worship, and under the auspices of traditionally entrenched rites, supports the validity of these narratives.[52] The second assertion is that there are probably entire compositions of varied interpretations given to African indigenous spirituality, which makes it confusing. The probability of this confusion is then best addressed by ensuring that discourses of indigenous spirituality are told from the point of view and understanding of the indigenous peoples, and not as perceived by outsiders.[52] Let the people who live it, describe it.[52] This will address the eradication of multiple interpretations of indigenous spirituality. For instance, a study might reveal a similar risk or protective factors identified across certain communities, but the particular ways in which the people within that community understand and engage with these factors based on their own unique experiences should be taken into account.[51] This is because culture is dynamic, multidimensional and ever-evolving, interacting with a changing context.[53] Thus, what might be naturally perceived as a negative action by an individual or a community by outsiders might actually prove to be an act of resilience, inspired by the meaning they attribute to life's stressors or risk factors.[51] Thirdly, it is critical to understand the context of oral traditions as an aid to gaining an authentic understanding of the concept or narrative.[52] These factors will help us explore understandings that could transcend

perceived differences and find a commonality related to spirituality and well-being towards a shared humanity that could serve both worldviews. Primary healthcare does not exclude culture; on the contrary, it is embedded within its context of implementation, seeking to collaborate with its context. The values of PHC advocate a knowing from the people it serves, rather than an imposition.

Culturally appropriate care

Spirituality is a foundational principle of the indigenous African communities, as I stated above. Western Christianity and healthcare institutions have become separated over time so that now Christian spirituality and formal healthcare operate as two separate institutions.[54,55] Within indigenous communities, there is no separation of spirituality from healing practices.[16,56,57,58,59]

As advocated by PHC, care should be about patient's needs, and its implementation should be centred on the patient, not the healthcare professionals.[60] A culturally appropriate and patient-centred care, as advocated within the PHC approach, can be reinforced through the recognition of the role of indigenous spirituality in the practice of well-being. The evidence of medical plurality and the fact that Africans always seek something more than what Western healthcare can provide is an indication of the significance attached to their beliefs related to spirituality. Leininger[46] refers to this as culturally congruent care. Culturally congruent care is aimed at dispelling the traditional notion of care as 'too unscientific', and culture as 'irrelevant and unnecessary', arguing that care is central to nursing and has a certain meaning attributed to it within different contexts.[46, p. 189] Within the *Bomvana* context, the establishment of trust is foundational to all care practices.

The establishment of trust, which is key to indigenous spirituality practice, will enhance the relationship between the healthcare professionals and the people that they serve.

Currently, within the *Bomvana* community, trust is negated by the attitudes of the healthcare professionals who see themselves as having superior knowledge, being the 'teacher' while people have to learn from them. Healthcare professionals are perceived by the community to be judgemental and disrespectful of their spiritual beliefs, with which they have existed. This realisation immediately drives a wedge in the doctor–person relationship. Research evidence shows that healthcare professionals' attitudes are one of the biggest barriers indigenous people face when trying to access healthcare. Recognising the role of spirituality within indigenous health practices would support culturally congruent care.

Although indigenous spiritual healing practices may not be based on evidential scientific processes as defined within Western literature, they are informed by context, considered to be practical, creative, mostly effective and time-tested.[56,60,61] The World Health Organization[61,62,63] also recognises the importance of indigenous healing. The successful complimentary use of both indigenous healing methods and Western healthcare approaches is being practised. Shai-Mahoko[60] discusses a situation in which rigid structural medical interventions were made for a child at school to support learning, while the family of the child performed family rituals to reunite his dead mother's spirit to the family to guide the child. The difference in their epistemological frameworks did not indicate a lack of cohesion in terms of the intended outcomes of each approach. Shai-Mahoko[60] insists that well-being is better achieved when both indigenous and Western healing practices are utilised. This is strongly supported by the fact that, although the majority of the world population has access to indigenous healing practices, there are still indicators of a poor health status within these indigenous communities. On the contrary, people who live amongst populations that have access to Western medication are facing the challenge of over-medication and high toxicity. We need to acknowledge that not every ailment requires a pill and could be addressed with alternative healing practices.[61]

Sustainable and affordable healthcare

The immense knowledge of traditional healers about medicinal herbs will greatly contribute to the treatment of diseases and conflict prevention and the sustenance of relationships achieved through various cleansing rituals to promote sociocultural well-being of communities.[60] A vast majority of black South Africans believe in these practices for well-being and utilise traditional healers;[60] therefore, it is paramount to ensure that the scope of practice of the indigenous healers is understood to assist in identifying points of collaboration. Even though the process of collaboration has been problematic, various arguments support the merging of indigenous knowledge practices within the PHC approach. Some of these reasons are that traditional healers are very accessible as they are part of the African culture and context; there is a lack of adequate resources in the developing context to address the health needs of the entire population. Traditional healers will support in the provision of culturally relevant and acceptable care.[59,63]

The level of connection traditional healers share with their communities portrays a sense, unlike Western practitioners, of traditional healers as not purely associated with illness by their communities, but rather with well-being as a whole.[64] Certain practices within traditional healthcare include issues of hygiene and induced vomiting, and unclear dosages of local medications have been cited as harmful to patients and needing some regulation.[64] However, collaboration between both knowledge systems can help regulate certain practices as required. The World Health Organization[65] revealed that the ratio of traditional healers to patients in sub-Saharan Africa is 1:500, while for the Western doctor the ratio is 1:40 000. So biomedicine will need to re-evaluate its positioning of the indigenous philosophical framework and seek collaboration to address the global health crisis. Also, given the fact that indigenous medication is available and affordable, exploring ways of practising collaboratively, holistically and transparently will help alleviate the current global healthcare crisis.

The indigenous healthcare practitioner as a resource

The indigenous healthcare practitioner can be a resource within PHC delivery in indigenous communities. I state this because, during this study, healthcare professionals who hail from the *Bomvana* community advocated for a merging of both indigenous spiritual healthcare practices and Western healthcare practices. The indigenous healthcare professionals straddle between both spaces and see both these practices as valuable. They are exposed to the benefits and challenges ascribed to both indigenous spiritual and Western healthcare practices, while negotiating their own medico-cultural tensions as they practice. These healthcare professionals should be ascribed a power-brokering role to mediate medico-cultural tensions because of their dual inclinations[66] and locate spaces of possible collaboration, as they have a more holistic perspective of these two healthcare systems. They must be supported to play this role. This will actively support the achievement of the PHC goal of creating, understanding and delivering healthcare that is informed by the target population. The mediation will help encourage the inclusion of indigenous spirituality into formal healthcare and will support culturally responsive care,[61] which is done transparently and openly, rather than with a hidden agenda.

Concluding statement

The indigenous understanding of spirituality is relational, placing the individual within the collective. This spiritual relationship is key to the *Bomvana* understanding of health and well-being, contributing to positive health outcomes for the communities. Spirituality is a foundational concept for indigenous African communities. It permeates every aspect of their lived experiences and informs their understanding and interaction of the world they exist in. It behoves any healthcare practice within African indigenous communities to ensure that it engages with this indigenous spirituality, which is critical to the well-being of

the communities. Primary healthcare is meant to be patient-centred, accessible and affordable, but the realisation of these has been challenging at the very least. The understanding and practice of indigenous spirituality and health practices has the potential to contribute significantly to a contextually relevant PHC. Primary healthcare addresses the social determinants of health, and its implementation cannot ignore such a foundational issue. Any aim of addressing holistic and sustainable well-being for communities must engage from a bottom-up approach, understanding their context, which is founded on spirituality.

Chapter 12

Savings, investments and credit groups: A holistic approach to community upliftment

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Introduction to and the background of the study

According to the people of Madwaleni, the *AmaBomvana*, socio-economic challenges play a crucial role in determining the health of a person. When the former apartheid government forced African men to leave their families and work in the mines in order to earn a living, not only did the government rob their wives and children of the father figure but they also ruined the entire family structure. While exploring the lived experiences of the older

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Xhosa women of *KwaBomvana* and how these women view health and illness within their context, Mji[1] makes us aware of how, over the years, the broken family structure has negatively impacted the health of these women. Ironically, their sons were convinced that the mines would provide them with better wealth that otherwise was impossible to achieve, but little did they know that that was the beginning of all forms of poverty that they and the community as a whole are presently struggling with. According to the elderly women of *KwaBomvana*, the mines shifted the focus of the *AmaBomvana* away from, and devaluated, all that was cherished by them. By undermining their own wealth and placing more value on money from others, communal ties became threatened. Sickness amongst these women in the form of worry and stress over shifted priorities and about their sons who were coming home from the mines in poor health and extreme poverty became the order of the day.

As part of the process to revitalise health and wellness (livelihoods) of the *AmaBomvana*, the Xanase community in Madwaleni recently embarked on a community collaborative self-help initiative using a savings, investment and credit groups approach for addressing socio-economic challenges that the community is grappling with. The author is a member of the scholar–activist team involved in various community projects in Madwaleni. She has also been working with a few other rural communities across the Eastern Cape province, promoting the concept of savings groups as a vehicle for strengthening community solidarity and addressing socio-economic challenges. As part of sharing experiences through process documentation, monitoring and impact evaluation, this chapter aims at sharing the experiences of savings group members about their participation in savings groups. The main reasons for joining the saving groups include the extent to which individual and group needs and challenges are met through the savings. This chapter intentionally focusses not only on the Xanase savings group but also includes experiences from two other groups – Mcheula and Ilinge – because lessons from these two advanced groups have

contributed to informing the establishment of the Xanase savings group that is still in the pilot phase.

An IKS reciprocal participatory approach was applied as a lens in engaging with savings and credit groups (SCGs). This enabled us to learn to cautiously share knowledge while being aware of the fact that the groups we engaged with were experts in local knowledge. This assisted us to continuously reflect on which knowledge to share and when to open a space for participants to lead the process and for us to learn from the process. We based our critical and developmental analysis of situations on both Nussbaum's[2] capabilities approach and within the sustainable livelihood framework (SLF). Finally, the chapter sketches relevant support identified by members that would enable them to achieve their goals, thus improving the efficiency of savings groups and contributing to the upliftment of the communities at large.

The exploration of the experiences of the savings group members with regard to their savings and investment is in line with the concept of financial inclusion forms that are part of the global agenda, an aspect requiring careful consideration to ensure its relevance to marginalised members of society and those it is directed to serve. These global discussions around financial inclusion date back to the G20 summit of 2008, when through the Alliance for Financial Inclusion, the world began to acknowledge that developing countries have a vital role in curbing the financial crisis the world was faced with at the time. The Global Partnership for Financial Inclusion therefore ensures that economic issues affecting the marginalised groups of people are taken into consideration when decisions are made. As a sign of commitment and accountability to making financial inclusion a reality, each country is expected to put in place relevant strategies that would ensure the inclusion of the local populace in the economic sector. It is for this reason that rural communities, and black African people in particular, need to be vocal about what defines them in order to be the best they are meant to be rather than assimilating what the world presents as ideal, which has at least failed them thus far. According to Inwork,[2] social exclusion

or marginalisation refers to the relegation to the fringes of society because of a lack of access to rights, resources and opportunities. Marginalisation is the major cause of vulnerability, which refers to exposure to a range of possible harms, and being unable to deal with them adequately.[2] The World Health Organization[3] further defines vulnerability as the degree to which an individual or organisation is unable to anticipate, cope with, resist and recover from the impacts of disasters. In the context of working with the savings groups, focus on marginalised and vulnerable groups includes people living in rural communities, the unemployed, the self-employed, people with disabilities, women, children and youth.

South Africa is widely known as the rainbow nation, an indication of the diverse population, currently estimated at 52 million people of various cultures, languages and religions that the country accomodates. According to the latest statistics, Africans form about 80% of the population, the majority of whom reside in rural areas.[4] Although South Africa has a relatively well-developed economy with steady modern financial systems and is rated amongst the top 10 African countries with its gross domestic product at $312.798 billion,[5] many rural South Africans can be seen as experiencing the vulnerability that has been described above by WHO.[3] In South Africa, the banking sector is considered the main driving force, followed by the insurance and pension fund industries. There are mainly four major banks in the country, namely, ABSA, First National Bank (FNB), Nedbank and Standard Bank, with the recent inclusion of Capitec increasing this number to five major banks that dominate the field of finance in South Africa.

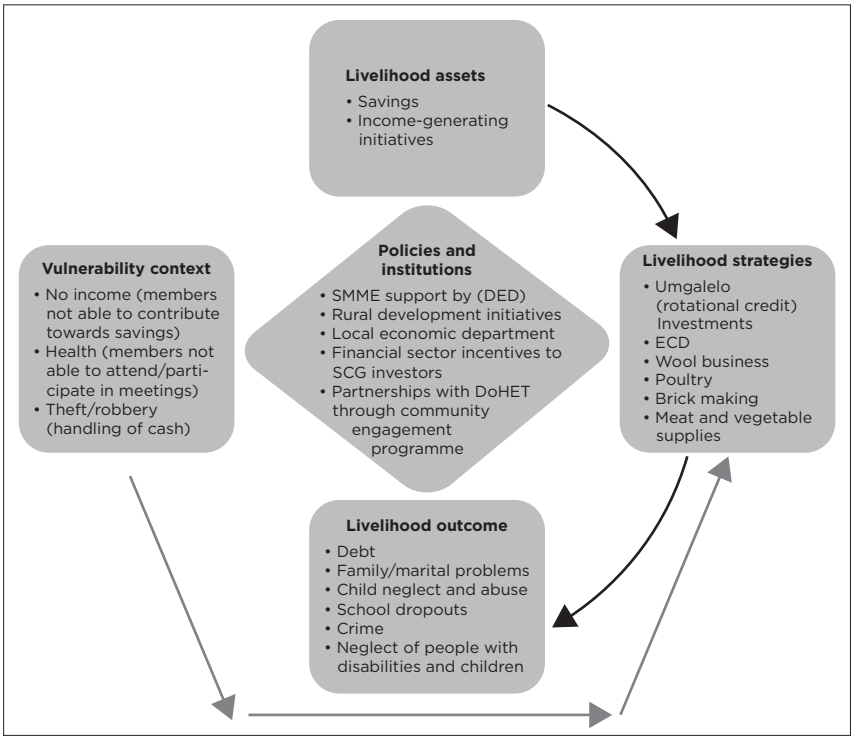
From a cultural perspective, personal experience indicates different approaches between the Western and African schools of thought with regard to managing or dealing with money. In order for the financial sector to be accessible to the African population, financial systems need to address cultural dynamics that tend to impact people's understanding and ways of dealing

with finances. Secondly, the issue of the banking system using English as the financial language presents a challenge to rural-based Africans, as the majority of them cannot read English, and more so because many of them cannot read or write. Within this rural group, there are other marginalised groups, such as persons with disabilities, who are also negatively impacted by this existing situation. This results in impounded marginalisation of these groups. It is within this context that the savings and investment group (SIG) approach saw a challenge and a gap for people residing in the rural areas in South Africa. This approach intended to draw on home-grown strategies of rural communities, characterised by a strong sense of community, and, to a large extent, upholding the value of *Ubuntu*. In the African rural culture, the community holds much value. It defines who the person is while offering a sense of belonging. It has the power to shape and inform one's thinking and actions, both consciously and unconsciously. Savings groups operate within the values of *Ubuntu*. For members of the savings groups, participation is not just about money but about a sense of unity, relationships and support that a person receives from others in time of need. *Ubuntu* connects people together. It is this aspect of solidarity within which SCGs operate that highlights their potential to impact not only individual members but also the community at large.

Theoretical framework

This study uses a sustainable livelihood approach (SLA) as the framework to assess the impacts of SCGs on members' livelihoods. According to the Department for International Development (DFID),[6] a livelihood is sustainable when it can cope with, and recover from, tensions and shocks, and maintain or improve its capabilities and resources, both at present and in the future, without deteriorating the natural resource base. An SLA seeks to enable the identification of practical priorities for actions that are based on the views and interest of those concerned.[7]

Key components of the SLA framework for analysing the livelihoods of individuals and the community are their capital assets, their vulnerability context and the transforming structures and processes (e.g. policies and laws) that influence the livelihood strategies that they adopt.[6] Figure 12.1 is a modified SLF where financial and non-financial (socio-economic) factors are categorised under the vulnerability context. The financial and non-financial factors affect the livelihood assets that impact the livelihood strategies of the



Source: Adapted from Serrat.[7]
DED, Department of Economic Development; DoHET, Department of Higher Education and Training; ECD, early childhood development; SCG, savings and credit group; SMME, small, medium and micro enterprise.

FIGURE 12.1: Conceptual framework: Sustainable livelihoods framework approach to supporting savings and credit groups.

communities to produce the livelihood outcome, as illustrated in Figure 12.1. Institutional processes and mechanisms also influence livelihood strategies, livelihood outcome, vulnerability context and access to livelihood assets. The study focusses on all of the five livelihood assets. The livelihood strategy focusses on the two livelihood activities, which are savings and income-generating activities.

The study adopts two theoretical approaches: The critical and the developmental paradigms.[1,8] The developmental paradigm, informed by the Afrocentric[8] and Nussbaum's capabilities approaches,[9,10] constitutes conceptual frameworks that inform the approach to data gathering. The critical theory (transformative paradigm) is the lens through which the data are analysed. Such an approach, as Richardson[8] argues, takes an overt moral and political position to the social problem analysed. The qualitative research approach allows for interaction between savings groups (inner world) and external conditions with its values based on humanity, '*Ubuntu*'. External conditions refer to the social, political and economic environment. Nussbaum's[9] capabilities approach acknowledges that external conditions play a major role in determining what the person does or becomes, while the Afrocentric qualitative approach puts emphasis on the subjectivity of participants, the context in which the person lives and the flexibility of the process.

Sustainable livelihood framework is an essential development tool that helps to understand, analyse and describe the main factors that affect the livelihood of the poor. Livelihood refers to the assets, capabilities and activities needed to make a living.[11] With a particular focus on placing rural people at the centre of development while exploring sustainable development options, the concept helps one to understand how people create a livelihood for themselves and their families.[11] One of the main problems faced by the poor and the vulnerable is that the processes that frame their livelihoods may systematically restrict them unless the government adopts pro-poor policies that, in

turn, filter down to legislation and even less formal processes.[6] An SLA is an important tool that can be used in planning and monitoring the relevance and sustainability of development projects. It is based on evolving thinking about the way the poor and vulnerable live their lives and the importance of policies and institutions. It helps formulate development activities that are sustainable, people-centred, responsive and participatory, multilevel and multi-sectoral partnerships.[6,10] It takes into account a variety of economic, social, political and ecological factors that impact a person's ability to sustain a livelihood. An SLA comprises five interconnected assets, namely, human, physical, social, financial and natural assets.[12] Most importantly, an SLA enables people to reflect on and acknowledge their innate abilities, social networks, access to physical and financial resources, and ability to influence core institutions.[6]

As a political doctrine, the capabilities approach is a relevant tool in policymaking, as it focusses on ensuring that opportunities are provided for citizens to at least have a dignified, basic standard of life. Both Nussbaum's[9] capabilities approach and SLA are considered relevant instruments for a study that aims at enabling community savings groups (a group that remains marginalised both economically and politically), yet a key resource to mobilising local economic development. The study adopted the sustainable livelihoods and capabilities approach (SLCA) in identifying and exploring experiences of SCGs within the Hani District Municipality. Our mixed-methods approach, applied in engaging with SCGs, enabled us to learn and to cautiously share knowledge in cognisance of the fact that the groups we engaged with were experts in local knowledge. We based our critical and developmental analysis of situations on both Nussbaum's[9] capabilities approach and within the SLF. Finally, the chapter sketches relevant support identified by members that would enable them to achieve their goals, thus improving the efficiency of savings groups and contributing to the upliftment of the communities at large.

Savings and credit groups through the lens of SaveAct

SaveAct, a non-profit organisation operating in the Eastern Cape and KwaZulu-Natal provinces of South Africa, promotes and supports the establishment of savings groups as an effective tool against poverty.[13] A study conducted in 2010 on relevant economic support to poor and vulnerable groups revealed that the poor use group savings and income generation (in the form of small businesses) to get out of debt and to build their wealth.[13] What is unique about the savings and credit group model is its method of pulling people out of poverty.

Savings groups, and microcredits in the form of small loans with affordable rates of interest, have the potential to facilitate participation of the poor in their communities towards changing their socio-economic situations for the better and in turn becoming self-reliant. This study seeks to explore the needs of the SCGs by finding practical ways to increase their access to resources, support them in the process and empower them to become agents of change. In most cases, women are often the facilitators for socio-economic support in their families. They are the ones that children often look up to when a need arises in terms of food, clothes, school fees, solving family crises, etc. People with disabilities, on the other hand, tend to depend on family and social grant support for most of their lives. It is in this light that women and youths with disabilities remain the focus of this study.

In its 10 years of operation, SaveAct has proved that when supported through developed (regulated) management systems and financial education, SCGs have a positive effect on the health, self-esteem, social well-being and general lifestyle of those who participate in them. SaveAct facilitates the formation of SCGs in rural communities with the aim of fighting poverty, building sustainable livelihoods and serving as a means to empower women and other vulnerable groups. The organisation's savings and credit model includes financial education, enterprise development training and ecosystems development, all of which

are aimed at breaking the cycle of poverty, and empowering individuals and communities to play more active roles in economic and social development.[13]

Participants in SaveAct saving groups are able to supplement their social grant sources of income through informal jobs such as selling sweets, chips and biscuits in their local schools and saving generated profits by buying shares from their savings groups. Not only did participants in SaveAct SCGs improve the conditions of their houses but also greatly improved the coping skills of those affected by HIV and AIDS through improved diets as they could afford nutritious meals. Participants reported feeling more confident at the end of the study than they had felt prior to participating in savings groups. Relationships with partners were also reported as improved with a strong sense of agency as they had provided their owner sources in the process: 'now I am in control of my life and can save for the future'.[14] The shortfall reported was that members tend to borrow more than they could afford, while SaveAct advises groups to lend only three times of what a member has saved. This study thus intends to interrogate this concept fully and work out what works and why it is needed to include collaborative, self-help approaches to addressing these problems. In addition, the future of the younger generation is also prioritised, and this is evident in how the savings groups are investing in ECD initiatives. The local language used was isiXhosa.

Data collection methods and analysis

Process of working with the three savings groups communities

All savings groups that were initially requested to participate in the study, except the Xanase, consist of members who have been working together for about 3 years. Similarly, when the groups were formed, local members who knew each other decided to start savings groups between 2013 and 2014. In the process of

establishing their groups, they were introduced to SaveAct, an organisation that supported them for 2 years until the end of 2015.

Brief description of the three communities including the poverty challenges they face

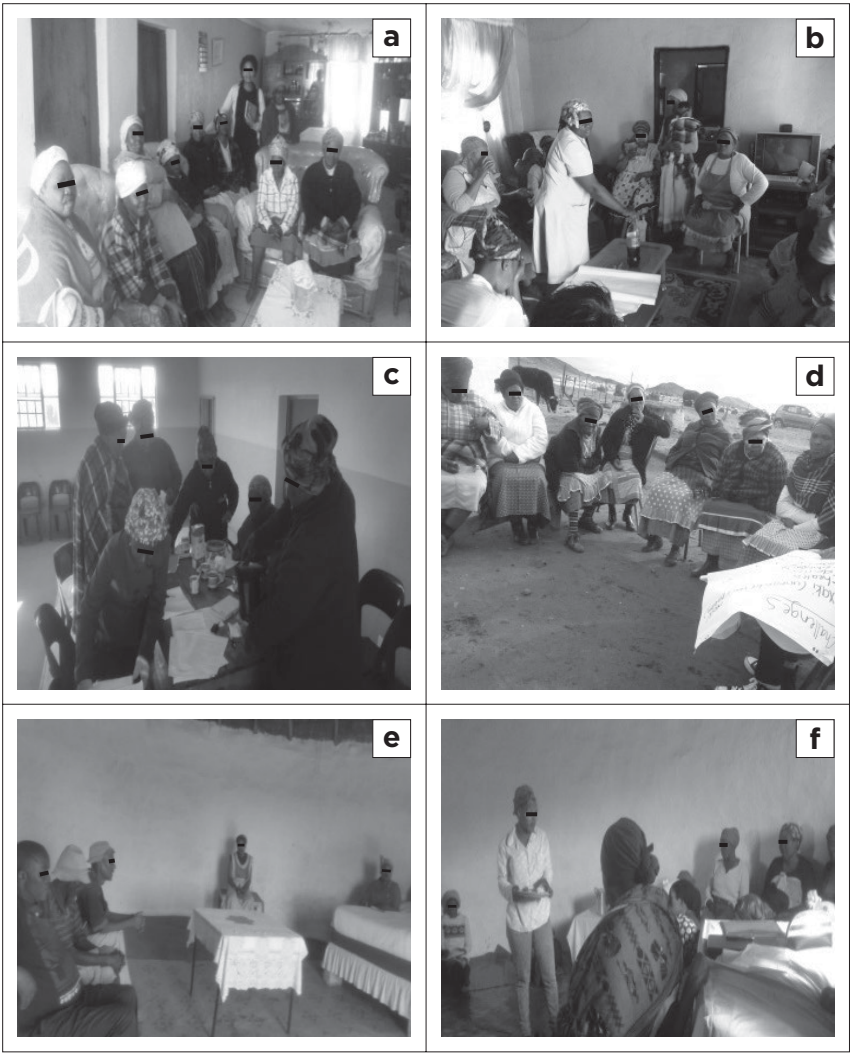
The three communities involved in the project are Ilinge, Mcheula and Xanase. Ilinge and Mcheula are located within the boundaries of the Lukhanji LM, while the Xanase are hosted within the Mbashe LM in the Eastern Cape province, South Africa. The Eastern Cape, with an estimated population of 6.8 million, is regarded as the second poorest province in the country after KwaZulu-Natal.[4] The province is largely rural, with the majority of its inhabitants relying on farming. The lack of jobs mostly affect women, youth, people with disabilities and the older generation, who have to take care of their grandchildren using social support income, as the rate of unemployment is high, estimated at 35.6%. As a result, the province is rated as having the largest outflow with regard to migration streams.[15,16] This can be attributed to the fact that people move to bigger cities, the Western Cape or Gauteng, to find work. Besides lack of jobs, research conducted across different provinces in South Africa associated the major barriers to employment for people with disabilities and youth, in particular, with poor health, minimal financial resources, inadequate skills and lack of access to, or minimal provision of, assistive devices. In addition, poor retention systems for education and training for skills development to ensure employability and inadequate support from family were further exacerbated by the discriminatory attitudes of the community and those in authority.[17,18] These are socio-economic challenges facing the communities of Madwaleni and Xanase in particular.

Observations gathered while engaging with Xanase savings groups and other savings groups within the Eastern Cape rural communities indicated that, despite the majority of local businesses being run by Somalians, within the savings groups, locals are slowly picking up on utilising local resources such as looking at ways to generate income, productive use of land and cultural

resources, including farming. It is also interesting to note the positive lesson(s) adopted by the groups from the way Somalians jointly conduct their businesses, which is evident in the way groups are moving away from an individual to a collaborative approach in running their income-generating activities.

Method of engaging with the three savings groups: In identifying relevant ways of addressing socio-economic challenges that vulnerable African communities are faced with, the focus on savings groups intended to explore ways in which savings groups can be supported to become sustainable. With the exception of the Xanase group, participants in this study were selected on their experience of participating in savings groups over a period of at least 2 years in order to be able to share their experiences and build on those as a way of supporting group efforts and making savings groups sustainable. Although this was the requirement to participate in this study, the project extended to include the Xanase group as this group was already organised with a community project and thus needed support in terms of formalising a consolidated approach for addressing the socio-economic challenges they had already identified. The researcher thus found it as relevant to include this community in the pilot phase, as it would benefit them to learn from the other community groups participating in the project. With challenges similar to other groups, the Xanase community group identified the need to help each other to get out of debt, particularly with loan sharks, to invest for the education of their children and to assist each other in times of financial crisis and funerals. Apart from the realisation that lessons learnt from this proactive community group would contribute towards informing future expansion of the savings group project to other communities, the researcher was already familiar with this community, having been involved in the bigger Xanase community project. For the purpose of triangulation, data were gathered in three phases using case study methods to explore the experiences of SCGs in the rural parts of the Eastern Cape province.

Figure 12.2 presents the pictures of the three saving groups.



Source: (a – f) Photographs taken by Ntombekhaya Tshabalala, from 2016 to 2018, at Ilinge and Mcheula, published with permission from Ntombekhaya Tshabalala.

FIGURE 12.2: (a – f) Meetings with savings group members in Mcheula, Ilinge and Xanase.

☐ Phase 1: Desktop review and initial interviews

Articles and reports were reviewed to get more information on the work of SaveAct and the relevance thereof to the needs of SCGs. In addition, in-depth interviews with the director and community field worker of SaveAct were conducted with the aim of getting an overview of the work done by SaveAct in supporting savings groups in the Eastern Cape. Simultaneously, the researcher accompanied the SaveAct community field workers at various savings group meetings as a way of introducing the study to various groups, getting to know existing savings groups and how these groups work. During this period, the researcher co-facilitated group meetings together with the field worker and established relationships with eight savings groups, namely, Masizakhe, Siphokuhle, Masakhe, Masincedane, Emfundisweni, Siyakhula, Masithembane and Basadi, with membership ranging between 8 and 20 members in each group. All of these groups were located in the Lukhanji LM within the Chris Hani District Municipality. From the total number of 170 members of the eight groups, only 117 members (four groups) participated in Phase 2 of this study. Reasons for not engaging included unavailability and lack of interest to participate.

☐ First phase of data collection

Data for the first phase were collected from the eight groups residing in the four villages within the Chris Hani LM. For convenience purposes, meetings were arranged on days when members would be gathering for their monthly savings meetings. In cases where individual meetings and financial diaries were conducted, these were organised a day before or after the group's monthly meeting. The researcher, sometimes assisted by an assistant researcher, facilitated the group meetings, except for savings group meetings that are always facilitated by the chairperson or any person appointed by the group in the absence of the group chairperson, as would be indicated in each group's constitution. Although the groups elect an executive committee, that is, chairperson, treasurer, secretary and two additional

members, for the purpose of managing their activities, every member is encouraged to play an active role by sharing roles amongst the members. During the first phase of the study, interview questions were directed at exploring the views of group members about savings groups, what it means for them to be members, benefits and challenges thereof. Data derived from these interviews informed the current phase, supporting and empowering savings groups to be sustainable and inclusive of their community representation, particularly people with disabilities who were initially not represented at all in the savings groups

Phase 2: Focus group discussions with participants

Focus group discussions (FGDs) were conducted with four SCGs to gather data on the experiences of savings group members regarding their involvement, needs and challenges. In-depth interviews with individual members participating in SCGs aimed to gather data on the experiences of members in particular, the main reasons for joining the saving groups, the extent to which needs are met and the challenges to meeting group and individual needs through the savings. An interview was also conducted with the Local Economic Development Unit (LED-Lukhanji) programme manager to determine programmes in place to support SCGs and to facilitate the role of SCGs in strengthening local economic development.

Second phase of data collection

The interview schedule (now revised, based on lessons from the initial phases of the study) focussed on addressing the research aims and objectives with a flexibility that allows questions from participants to be addressed in the process.[19] These semi-structured interviews made it possible for group members to share valuable information and, in particular, personal aspirations, beliefs and general information with

regard to family issues that have drawn them to participate in the SCGs that they are part of. All the communication was done mainly in the participants' mother tongue, isiXhosa. An audio recorder was often used to record group meetings with the permission of the participants.

☐ Phase 3: Pilot phase for the implementation of recommendations

Informed by findings from Phase 2, the researcher continued working with two of the groups' SCGs supporting with the implementation of recommendations.

■ Research design, identification and selection of study participants

This qualitative exploratory research study used a case study method to gain insights into the existing SCGs within Chris Hani and Mbhashe municipal areas.[11]

The first phase of the study focussed on establishing the main reasons for joining the savings groups, identifying individuals' and groups' needs, including barriers to meeting the group, and individual needs using generated savings. In order to build trust, the researcher initially attended various group meetings as an observer and later on assisted as a co-facilitator, facilitating group meetings together with the SaveAct field worker. Group members were then invited to participate in the study. Non-probability sampling method was used to select beneficiaries who were all active members of the SCGs. Snowball sampling was also used with groups recommending other local groups as potential participants who were also requested to participate in the study. All of the existing savings groups that were identified and requested to participate were included in the study and only those who did not show an interest in participating were excluded. The current phase, the pilot phase of the study, extended the

Source: (a–c) Photographs 1–3 taken by Ntombekhaya Tshabalala, from 2016 to 2018, at Ilinge and Mcheula, published with permission from Ntombekhaya Tshabalala.

FIGURE 12.3: (a – c) Discussing findings with savings group members in Ilinge, upper Didimana and Mcheula.

project to include one recently established savings group, the Xanase Community Savings, Credit and Investment Group. Located within the Mbhashe District Municipality, the Xanase savings group has the largest membership (*N* = 86), with the participation of all the 77 households within the village.

Data analysis

Thematic content analysis was used for analysing the data, with themes emerging through the transcription process being continuously reduced into themes.

Initial findings

In presenting the findings, I first present findings on the first phase of this study, which involve all participating groups with the exception of the Xanase savings group. These are the groups that had been in operation at least for a period of 2 years at the time of engaging in this study. Data analysis was conducted inductively and thematically. In the discussion, the interpretation used sustainable livelihoods as a framework.

Presentation of initial findings for the first phase of the study

This area covered the following themes: Mapping out categories of needs, current activities conducted by the group members, achievements in participating in savings groups and challenges to participation and achieving personal goals.

Mapping out categories of needs

Reasons for joining savings groups included interventions by acquaintances who introduced members to savings groups in trying to help them deal with family problems, such as marriage-related or financial problems. Some members voluntarily joined because they saw how supportive members were towards one another. Although each individual had a personal goal to pursue by joining the group, there was a shared goal: saving money to attain something.

Identified reasons for joining the groups

The reasons for joining the groups were:

- to save money to buy groceries at the end of the year when the family gathers together for Christmas
- to start up small businesses of selling fruit and vegetables and brick-making to supply to local builders
- to explore alternative ways of saving

- to buy clothes and school uniform for children
- to pay school fees and invest money for tertiary education
- to save for initiation ritual costs
- to build or improve homes
- to supplement household income.

Current activities conducted by the group members

There are activities that members do jointly as a means to support one another and to supplement their savings. These include monthly group meetings, often conducted on agreed days, to pay contributions and pay outstanding loans. One of the groups uses part of the monthly contribution to buy vegetables, sometimes meat, as a group for personal use or for selling locally to families in the area. Profits generated are then invested back to the group savings.

Activities that members are involved with individually

Individually, members are involved in the following activities:

- farming
- hawkers and spaza shop
- sewing and beading
- local burial societies
- brick-/block-making (but on hold because of financial challenges)
- early childhood development centres.

Following discussions about creating practical ways for members to generate income using innate skills and local resources, the researcher bought a calf from one of the group members, Mr Mali, who is a local cattle and sheep farmer. The arrangement was that the cow would remain in the care of the farmer at an agreed monthly fee for taking care of the cow

while mentoring a local young man, Xoli, who could not afford to pursue his interest in agriculture because of financial challenges. Xoli agreed that at times he would assist Mr Mali in looking after the cattle (vaccination, grazing, etc.), while being mentored by Mr Mali. The two keep a diary of time spent together, noting activities and lessons learnt. During community engagement visits, the researcher meets with Mr Mali and Xoli, discussing lessons and challenges. Xoli receives R7 for every hour of support and sometimes attends meetings related to knowledge sharing/skills development in guidance/mentorship by Mr Mali. Xoli has now also joined the savings group with the aim of buying a calf and a lamb.

Achievements in participating in savings groups

Less than half (approximately 40%) of the participants confirmed that participation in SCGs has contributed to meeting their needs, but the needs met not necessarily concurred with reasons why they joined the groups. For example, there are members who joined the groups because they needed to raise more cash to buy building materials and to build their homes. A few of these members have managed to use their savings to actually buy building materials and build their homes. Because of unexpected family needs, others ended up using their savings to accomplish other family needs, which they would not have been able to attend without the group savings. For this reason, participation in savings groups is considered worthwhile as this enables one to meet family needs.

Challenges to participation and achieving personal goals

In some of the groups, there were members who left because of relocation and others who could not afford to commit to group meetings and contributions. One of the challenges in the past was to get payments on time and members attending meetings timely:

> At that time, we did not know each other well like we do now, and there were fears that anything wrong might happen because it was not easy to trust having not worked together before. Now we are like a family and everyone is committed to the group. (SCG member, undisclosed gender, 2016)

Although penalising for not attending or arriving late at meetings was an option, most of the groups decided not to take that route but to cancel membership when a person is late or does not attend meetings on three occasions. This seems to have worked as none of these are a challenge at present.

Since the groups started, none of the members have managed to start or to contribute savings towards businesses, with the exception of three members, although this is the area of interest for the majority of the members. The main reason noted for not being able to save for a longer period is family commitments, which often occur unexpectedly, and this seems to be the main challenge and an area that the groups need support on.

Fear of the unknown/lack of confidence/ fear of growth

There seems to be a growing interest on the part of the local populace, including people from neighbouring villages, to join savings groups, but members do not feel comfortable about increasing the group numbers as they think it will create more challenges regarding control and administration. In addition, the group feels secure working with members they have grown to know and to trust over time.

Findings for the second phase

For the Xanase community, the interest in starting a savings group developed as a result of concern amongst the community members regarding the financial challenges that families were going through, which was in turn making it impossible for their children to attend tertiary education. The researcher (the author),

who is part of the 'scholar–activist' team involved in the larger Madwaleni community project, shared information about the savings group concept and the community members saw the approach as a perfect fit in advancing their collaborative efforts to get out of the poverty trap. The process of starting a savings group then became, during the community project meeting, one of the larger community engagement project objectives. This meant the involvement of the entire community of Xanase right from the conceptualisation of their savings group. Amongst others, reasons identified for establishing the savings group included the following:

- The majority of people in Xanase had loans and were struggling to get back their identity document (ID) books from loan sharks because of not being able to pay up their loans.
- The majority of youth stayed home or had to find work after matriculation because their parents did not have money to support their tertiary education.
- Learners needed money for their matriculation farewell, winter school fees and other educational costs.
- Burial costs were often a challenge as many of the community members did not have funeral policies.

It was for these reasons that the community members took a decision to start the Xanase Community Savings, Credit and Investment Group.

Presentation of findings and discussion for the third phase of the study covering all groups

The SLA is used to give an analysis and presentation of the situation in which the savings groups operate and to assess changes that have happened as a result of participating in savings groups. This is done by identifying the degree to which the activity performed is responsible for the change that has happened. Impact is measured by assessing the accessibility of the five assets for sustainable livelihoods. As this is an ongoing

study that intends to identify relevant support for savings groups to be sustainable, an SLA will assist in further guiding, monitoring and evaluating the impact and the relevance thereof to members and the context in which they operate.[7] An SLA enables people to reflect on and acknowledge their innate abilities, social networks, access to physical and financial resources, and ability to influence core institutions.[7]

In this section, five interconnected SLA assets, that is, financial, social, human, physical and natural assets, are discussed in relation to the impact they have on savings groups and how savings groups manage these in their various contexts.

Financial assets

In order to understand the impact of savings groups on members and the community at large, we looked at the current sources of income and how members manage their needs through their incomes.

Household income

All of the participants received some form of income. About 115 of the 117 participants received SASSA grants (child support and old age grant) as monthly sources of family income, aside from the salaries received by nine participants with formal jobs (caregivers and managers in ECD centres). Income-generating activities also contributed some form of income for 12 of the participants, although these were on and off activities. Only three of the 12 members involved in income-generating initiatives (IGIs) were consistent in running the business, while the rest would take breaks for about 3 or 4 months and resume again. However, the members were certain that income from IGIs made an important contribution to their family income.

It is important to note that farming was generally a 'lifestyle', as almost every household was involved in some form of farming with goats, sheep, pigs or cattle. Other than the wool

that is currently produced and sold to the Department of Agriculture, none of the members looked at how one could generate income from their existing farming skills. Amongst the activities that are currently piloted to establish viability to generate income is an initiative on how farming as a hobby can generate income.

☐ Social assets

The most valuable and unique aspect that differentiates the savings groups from the conventional saving or banking sector is that the savings groups are based on the values of *Ubuntu*. From personal experience, having spent my entire childhood in rural communities, I have witnessed and learnt that with money one can manage to buy a loaf of bread, but with supportive people around one can survive even the hardest times in life. This is key to the sustainability of the savings groups, and this is evident in the way the groups operate.

Although members associated savings groups with money, social benefits in the form of networking and supportive relationships came out strongly when the participants shared their views about the benefits of participating in savings groups. Below are some excerpts from various FG sessions:

> I joined the trunk in order to support grandchildren. (SCG member, undisclosed gender, 2016–2017)

> I was referred to the group by my neighbour, who saw how I was struggling supporting my children. (SCG member, undisclosed gender, 2016–2017)

> I had lots of debt from loan sharks as I used to rely on them before joining the group. The group supported me so much when I joined with all the stresses and frustration as a result of not knowing how to get out of that trap. Sometimes you get frustrated at home calculating sums that do not add up but when you come to the group meeting, just being in the company of other members is like taking off a burden off your shoulders. (SCG member, undisclosed gender, 2016–2017)

> Initially joining the group helped me to settle all debts, tubing (electricity at home). And last year I bought material and build kraal at home and bought clothes for children. The savings are very helpful '*ngakumbi nangakumbi uyafunda komnye nomye kwaye akukho mntu umonela omnye*' [*most of all you learn from others and jealousy does not exist*]. (SCG member, undisclosed gender, 2016–2017)

Unexpected family needs, such as those related to health, death, school activities like winter school fees, etc., often affect budgets and monthly contributions towards group savings.

☐ Human assets

This chapter indicates that participants across the three sites acquired skills by observing family members, particularly activities taught by parents that the members were expected to perform at home. Although the members are involved in various activities that generate income, none have any formal training. These are skills in sewing, beading, farming, brick-making, poultry, cooking and catering. For members to specialise as service providers, they would need support for fine-tuning those skills. There are no local schools currently for this purpose. An interesting discussion also took place in one of the group meetings about how local Somalians can work together or engage in conversations with SCG members, with the aim of sharing and exchanging knowledge as Somalians often do well in business. The few Somalians who have been approached with this suggestion welcomed it and saw it as an opportunity to strengthen relationships with local people. The major concern that emerged regarding the approach taken by Somalians in running local businesses was whether they were sharing business skills with the aim of supporting and empowering local business-minded people, or whether they were working towards owning all businesses. Some of the local unemployed youth are involved in the construction of houses locally and the basic skills they have in construction, plumbing and painting have been acquired mainly through working as labourers in construction firms they had worked for in the past.

Very few of these youth, men in particular, are involved in savings groups, although through 'sweat equity' they participate by supporting parents who are involved in the brick-making business. These youth have also been significantly involved in the currently constructed ECD building spearheaded by one of the savings groups.

Physical and natural assets

Some of the groups had considered ploughing fields as a group project in order to supplement savings, and then sell the produce locally and also supply to schools; however, with severe drought in the past 2 years, 2015–2017, that was not possible. Despite their combined effort to pay for a local truck driver to source water from nearby water points (river and dam), this could not work as they could not afford the cost thereof from their savings. Animal theft was also a challenge that affected their seasonal income from selling wool from their animals, and again with the savings alone it was not possible to erect fencing.

We do not want to work with banks

The issue of keeping cash amongst themselves seems NOT to be a challenge for the group BUT rather getting the bank involved. Involving the bank '[…] is like donating what we don't have which contradicts our purpose to make more money as a group' (FGs, July 2016).

In engaging the groups on the issue of safety, the members responded that they feel safe retaining their money with them, while the bank only takes money from them with no support provided in return. Members preferred considering an option of opening an 'investment' account where they will not have to pay for the period the money remains in the bank, instead they will be paid for depositing their money in the bank which has access to it while in their care.

Deeper analysis of challenges, disappointments and areas of dissatisfaction indicate that members grappled with issues of

trust at the initial stages of joining the groups. They saw members who did not pay back their loans as not 'honest'; however, an interesting discussion during FG sessions confirmed the SaveAct[14] finding that members tend to struggle to pay back their loans because of borrowing beyond their ability to repay. One member responded during the FG session:

> Reflecting during this period has helped us learn from our mistakes, there are people who left the group because we did not trust each other. We accused them of not being honest but thinking about it now we realise that it was not just about being honest or not [...] people take more and end up struggling but we have learnt to listen to one another and to learn from our mistakes. (SCG member, March 2017)

Identified unexpected family needs that often affect budgets and monthly contributions towards group savings are health, death, school events like winter school, boys going to initiation schools without informing parents. The majority of members had, at some point, to pay medical fees in cases where a member or someone in the family fell ill. Similarly, there were cases where members had to attend to funeral costs using the money they had set aside as contribution to saving groups.

We save only when in trouble and still struggle to make this a habit

By virtue of belonging to a community, members are expected to lend a helping hand should a community member die. This often comes as an unexpected additional contribution for group members as they have to pay monthly contributions towards supporting the family in mourning. This realisation has brought in more discussions about ways in which members can refocus their efforts in such a manner that unexpected needs are taken into consideration while operating their savings groups. Although they participate in savings groups, they believe that learning more about the concept and various ways of applying these in their groups will help make their groups more effective. They believe that the concept of saving needs to be inculcated as a way of life so that their children can learn from the way they do

things and develop the skill while they are still young; 'we save only when in trouble and still struggle to make this a habit' (SCG member, undisclosed gender, July 2016).

Lack of self-trust and fear of the unknown

Members struggled with trust issues as there were disappointments in the past when they started, but not anymore. However, there is still resistance in terms of growing numbers and accepting more members and resistance is attributed to fear of the unknown, such as *what changes will this bring to the group*, *would members cope/survive challenges*? In addition, self-belief or confidence deters group members from trying alternative ways of doing things, believing that, 'I am poor to do other things in life [...] What if I lose the little that I have?'

Further lessons and unexpected discoveries

The SLA is based on the evolving thinking about the way the poor and the vulnerable live their lives and the importance of policies and institutions.[7,12] Understanding the context in which the savings groups operate enables the unfolding of a holistic, people-centred, appreciative, multi-sectoral and sustainable development process. Such a process values local people's knowledge and acknowledges that they are the best experts of their own development, and thus they need to be supported with the necessary skills to unleash their innate abilities.

Findings on the experiences of savings group members indicate that the savings groups are valuable assets, both financially and socially. Participants joined the savings groups in order to supplement family income, which was mainly derived from government social support grants. They have managed to do things that they were not able to before they participated in the savings groups, as one participant shared:

> *ndandilixhoba... Kodwa oko ndangena kuletrank, ndiqamela ngemali kude kufike elinye ixesha lokwamkela into engazanga yenzeka*

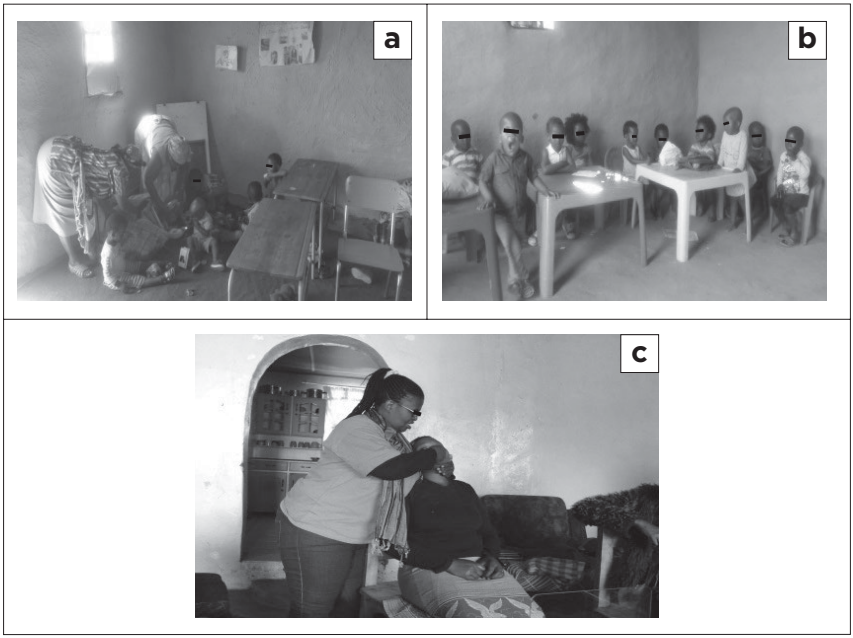
> *ngaphambili…ndandisaziwa yile lali yonkendilixhoba loomatshonisa* [I used to be a victim to loan sharks but since I joined this group, I sleep with money under my pillow, I even lose track of pension days since I now don't run out of money, the thing which never happened before. Everyone in this village knew I was a victim to loan sharks]. (SCG member, undisclosed gender, 2016)

This suggests that with support from the local government, particularly the Social Development and Local Economic Development Unit, relevant strategies can assist in supporting the efforts of the group members and in protecting them from being victimised.

Another crucial finding is that, despite not being informed of alternative ways on how to best invest their savings, rather than through internal interest-bearing credits or loans, all of the savings groups participating in this study expressed that they do not want to work with banks. For them, it just does not make sense to put their savings in the bank, as they see this as, 'sponsoring the bank with the money they do not have, what do banks do for us […] nothing' (SCG member, 2016). Indeed, having a bank account is good enough for the banks, as they benefit through lazy deposits often received from savings groups or stokvels for short-term investments, with nothing in return for savings groups. Thus, Mulaudzi[20] suggests a need to shift conversations around economic transformation from financial inclusion to financial mobility, if we are to effectively support and empower savings groups that currently contribute significantly to the country's economy. Interesting to note in engaging with the groups is that while both the loan sharks and the banks charge interest for a loan, which is often higher with the loan sharks, there is more resentment towards the bank than the loan shark, with loan sharks seen as supportive and a reliable source to fall back on in times of need. Also, the banks charging bank fees for maintaining a savings bank account does not help their cause. An SLA acknowledges that savings groups have a vital role to play in informing an inclusive financial sector, as they know best about their needs; their voice is vitally important.

Across the groups, there are members who joined through referral by neighbours or people who were already participating

in savings groups because they saw value in the support they received from their fellow group members. Each of the eight groups has an ECD centre run or supported by members of the group. This started because there were members who had children that they brought with them to meetings because they had no one to leave them with at home. During the meetings, members would take turns taking care of the children, while a parent attended to bookkeeping or writing minutes. Members then saw an opportunity to start a local ECD centre, inviting neighbours to bring their children that they take care of for a monthly fee. While members saw this initially as a potential source of income to supplement their savings, they are experiencing problems with getting the majority of parents to pay the monthly fees. The groups seem to have 'adopted' these



Source: Photographs taken by Ntombekhaya Tshabalala, in (a) October 2017 at Ilinge, (b) November 2017 at Mcheula and (c) July 2017 at Ilinge, published with permission from Ntombekhaya Tshabalala.

FIGURE 12.4: (a–c) Early childhood development centres run by parents and a parent advising on taking care of children with disabilities.

centres as a way of supporting and taking care of local children. Discussions are now on about how the groups can develop these centres through a portion of their savings to become sustainable with the hope that, in the long term, income from fees will help supplement savings through jobs of caregivers running the centres. Through donations from community members, a one-room building has been constructed that will see children relocating from a currently home-based 'crèche' to the recently completed structure. A soup kitchen and vegetable garden has been initiated by another group. With the support from the research team, group members are empowered with skills on how they can include and stimulate local children with disabilities in the ECD programme. They are also supported in the process of registering their centres with the Department of Social Development. This shows how dynamic savings group meetings are. Members do not only focus on financial challenges but also on addressing social challenges experienced by group members and the community at large.

Future research

***The Financial Resource Centre Model*:** Promoting locally based collaborative and inclusive self-help initiatives in addressing socio-economic challenges, the 2030 Agenda for Sustainable Development Goals (SDGs) aims to reduce the percentage of people living in extreme poverty to zero by 2030. This means that the vulnerable and marginalised groups need to be at the centre of our efforts to achieve this goal. The initial findings about the savings groups indicated that there was not a single person with disability participating in the savings groups. However, after engaging the groups in discussions about the concept of disability and perceptions about disability, interesting views began to surface during group discussions. The members started discussing ways in which they can invite and ensure that their actions encourage participation of the local people with disabilities. They saw it as important to invite new members who had people with disabilities in their families. They further saw it as important

to first engage family members in discussions around disability inclusion, which are currently part of group discussions. Currently, both of the groups involved in the pilot phase have people with disabilities participating. For group members and families, it is interesting to observe the mind shift in discussions about how people with disabilities can control their income, work on their budget plans and at the same time contribute financially to their families, with adequate control over their finances. This move towards encouraging the involvement of people with disabilities in the savings groups has the potential to develop their self-esteem and ensure that people with disabilities are respected, which they rightly deserve.

The Financial Resource Centre Model aims to broaden the mindset of disadvantaged communities, one at a time. Working together with SIGs, the aim is to intensify local capacity using self-help approaches and initiatives to financial inclusion by mobilising and supporting communities through the SIGs, as well as establishing financial resource centres (FRCs) as the contact points for local people in times of financial challenges. Through these FRCs, communities cohesively interrogate day-to-day individual, family and community issues that deter them from achieving their financial goals. The methods of engagement with community members are FG meetings and individual meetings. Focus group meetings are platforms where community members discuss and explore ways of addressing local challenges impacting their financial freedom. Individual meetings aim to support individuals and families in addressing financial challenges and also allow for the expression of concerns that may be difficult to discuss in an FG. Simply put, FGs provide a broad insight into collective views, whereas the individual interviews allow for more private expressions of views uninhibited by any tacit intimidation that could be present in the FGs.

The unique component of the FRC model is that the marginalised people do not just get direct support to address financial challenges but become actively involved in finding their own relevant solutions to address their problems. They cohesively

explore possible solutions that keep them grounded and appreciative of that which defines them and what they have, acknowledging the power of togetherness as the vehicle to get them where they aspire to be.

The model also ensures that management structures are inclusive of people with disabilities and women and that they are supported and empowered with relevant skills to actively participate in these structures. In this way, issues affecting people with disabilities, youth and children are taken into consideration when addressing the socio-economic challenges at the community level.

By empowering SCGs as alternative FRCs at the local level, restrictions to marginalised groups in economic participation will be curbed, thus creating a mind shift from stigmatising and discriminating people with disabilities, the poor and the unemployed, and the rural communities. In addition, socio-economic challenges that communities grapple with will be interrogated at the community level for introducing solutions that are more relevant to the needs of various communities.[25] This shift towards disability and inclusion of vulnerable groups at the local or the community level will help challenge the barriers that exclude people with disabilities from mainstream activities in societies. Likewise, the participation of women and girls in SCGs, and in particular at the leadership level (as initiators and drivers of such initiatives), will challenge society to rethink and appreciate the crucial role played by women in uplifting families and communities.

Conclusion and future project direction

Lessons learnt from the initial phases of engaging with SICGs indicate that, for less than half of the membership of the SICGs, participation in savings groups has contributed to meeting their needs, but the needs met did not necessarily concur with reasons why they joined these groups. The main area of disappointment

was lack of honesty; however, the group later on realised that it was not necessarily about honesty but about the inability of people to repay loans after borrowing more than what they were able to afford. As they put it, 'people take more and end up struggling but we have learnt to listen to one another and to learn from our mistakes' (SCG member, March 2017).

Members joined savings groups with expectations of what their savings would help them achieve. They wanted to build financial security through savings in order to build or improve their homes, to furnish their homes, to supplement family income, to start or boost their businesses and to secure money that would assist them to pay for their children's education. However, although participation in savings groups has enabled some of the members to contribute towards costs of building their homes, they still struggle to furnish them as a result of incurring costs by way of buying furniture on credit. Members get distracted from building on their savings, as they find themselves having to buy necessary household equipment, such as fridges, stoves and gas heaters, and pay for emergency needs, such as funeral costs, medical costs, including animal care, and initiation rituals that occur unexpectedly for parents. Most important to members across the groups that participated in phases 1 and 2 of this study is that most of them managed to settle loans that they owed to loan sharks, which has evoked feelings of 'emotional freedom'. Participation in savings groups has offered a supportive space where members find it easy to share frustrations and have time to reflect on their actions, which they find difficult to do when going through difficult times in their homes.

Despite these benefits and achievements, members still find it difficult to pay monthly contributions when emergencies arise in their families, which exert pressure and causes group frustration. These findings support the previous study by SaveAct[13] that with the financial capacity to deal with risks, as a result of non-payments and late loan repayments, participation in savings groups has positive effects for health, relationships and confidence. The findings confirm that the banking sector

and the government have a vital role to play in supporting SCGs to be sustainable. Savings groups are essential informants on local economic development, and therefore their participation in developing local Integrated Development Plans (IDPs) is important.[21,22] Local economic development, the conduit for implementation of policies at the local level, in partnership with savings groups, can cover more ground, creating a financially inclusive society.[21,22] Valuable information has been shared as to why there is resistance with regard to savings groups working with banks, highlighting a lack of understanding about financial benefits for them and, in particular, not understanding the foreign processes guiding the banking sector.

The Financial Resource Centre Model aims to broaden the mindset of disadvantaged communities and to intensify local capacity using self-help initiatives for financial inclusion. By empowering SCGs as alternative FRCs at the local level, restrictions to marginalised groups in economic participation will be curbed, thus creating a mind shift from stigmatising and discriminating people with disabilities, the poor and the unemployed, and the rural communities.

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Chapter 13

Community engagement in KwaXanase: Moving from fear to pride and confidence

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Introduction

Through engaging in community development initiatives, it becomes evident that apartheid, capitalism and industrialisation, in particular, have negatively impacted rural livelihoods. Migrant labour has not only robbed the older generations of their health and social capital but also blinded the younger generations in valuing the wealth of their possessions and possibilities of how rural living can be fulfilling. This has resulted in communities that strive for that which is Western and foreign to them. For the younger generation, success is determined by one's ability to secure a job in urban areas. Ironically, working for a boss and being paid peanuts carries higher recognition and esteem than ploughing their fields and minding their flocks and herds. These are the realities that the *Bomvana* people have decided to confront through the Xanase community project. Stemming from Mji's[1] research findings, the Xanase community project aims to address the root causes of ill-health and lack of well-being of the community, identified as the socio-economic ills affecting the larger *Bomvana* community in Madwaleni.

This chapter, as part of the translation and application of the research findings and recommendations from Mji's[1] PhD, will focus on the process of community engagement in one of the villages at the research site. The chapter aims to give a chronological account of the process and progress of engagement with the community of Xanase village from December 2014 to September 2018. Xanase village is one of the nine villages in the vicinity of Madwaleni Hospital in the Mbashe municipality where Mji[1] conducted her PhD research. There are approximately 70 homesteads in the village, with between 5 and 10 people in each household. Being the farthest away from the hospital and the main roads, when Mji first visited the village, seeking the most neglected village in the area, there were no roads at all leading to the village, and only rudimentary tracks were present. Because of this, the village was amongst the last to receive municipal services, such as ventilated improved pit latrines (VIPs), any form

of water supply (other than the nearby rivers and distant springs) and is still without electricity. As with most communities subjected to colonialism, exacerbated by apartheid policies and philosophies in South Africa, and more recently neoliberalism, international and national elites have indoctrinated national and local political leadership over the years.[2] In addition, policymakers, administrators and health professionals have adopted policy frameworks, technologies and system designs that exacerbate the existing inequalities, and disempower communities in deeply hegemonic ways.[2] The local support structures and cultural beliefs and practices of most marginalised, particularly forgotten rural communities, are the most affected by neoliberal policies.[3] From the perspective of health, the supremacy of a biomedical model, introduced by the early colonisers, has increasingly propagated a medicalised understanding of health and development.[2] The health profession has instilled a belief that sees biomedical interventions as the best way to achieve health. This biomedical model carries a particular form of knowledge associated with its values and belief systems. This knowledge is very often in contrast to the knowledge of people's own lives and lived realities. It is also often in contradiction to the view of health that most indigenous communities hold, seeing health as a system wherein humans, animals, the plants and the environment are one, and being healthy is not merely the absence of disease.[1,2,4,5] This is similar to the view held by the elderly isiXhosa women in this area.[1] These communities also gain the least from the present dominant development models.

When the scholar–activist team first started engaging with the Xanase community in 2014, they found a community that looked only at their deficits and their needs. The community suffered not only from financial poverty, but also poverty of the mind and spirit.[6] That was in December 2014. September 2018 portrayed a very different community (see Table 13.1 illustrating progress over the years, from 2014 to 2018). The community still suffered from financial poverty but no longer displayed poverty of mind or spirit. This was now a community that insisted on hosting and

TABLE 13.1: A brief chronological account of processes and progress from December 2014–September 2018.

Date	Process and progress
December 2014	Initial community workshop; early childhood project commenced soon after
April 2015	Visit to Bulungula regarding cultural tourism and early childhood project
August 2015	Opening of bank account for funds that have been secured to assist with buildings initially
2015	Ventilated improved pit latrines installed by the LM
2016	Water tanks delivered by the Department of Rural Development and Agrarian Reform
July 2016	Conference at DWF, Hobeni village
November 2016	Three rondavels nearing completion
April 2017	Rondavels completed, but still need furnishing. Two pit latrine trenches have been dug, but structures were to be built
June 2017	EC expert accompanies the team to give some training to the EC facilitator
January 2018	Beginnings of savings clubs
April 2018	The ECD project moves to one on the rondavels
September 2018	Students from the United States visit the project and the rural conference is held

DWF, Donald Woods Foundation; LM, local municipality.

organising all the logistics for a truly rural conference that was planned for 18–19 of September, 2018. This was part of a series of rural conferences in this area to connect with the rural people that are part of the community engagement process. The first one was tabled in July of 2016 at the Donald Woods Foundation (DWF) Centre. For the second conference, we opted to use our community engagement strategy and hand over the organising of the conference to the Xanase community group, with us facilitating from behind.

Although it was partially risky, we had been engaging with this community over the past 4 years and had trust in the process.

When some members of the scholar–activist team arrived a week before the conference to check on the progress, they found an excited and organised community, slightly nervous and

apprehensive, but filled with confidence. The venue had been secured, with the community contributing to the hiring costs. A team of caterers had been established and the menu for all meals, with all quantities calculated, was clearly documented. They also intended to involve children in the conference by making them recite poems. Some were about their own development, schooling and how the present government is supporting the rural child through child support grants. They had also prepared some indigenous songs and dances.

The day after the conference ended, members of the scholar–activist team and the Xanase Community Development Committee, as well as the catering team and some youth volunteers, reflected not only on the conference but also on the events and processes from the first community workshop in December 2014. This reflection was initiated and stimulated by 60 printed photographs that chronologically photo-documented events at certain points along the journey from 2014 to 2018. These photographs were put up in a hut in the village for a week before the conference and then moved to the conference venue. The photographs were used as Freierian 'codes' to promote reflection and discussion.[7]

This chapter gives a brief chronological account of what has happened in the village from the first workshop in December 2014 and culminating in the conference in September 2018. The focus of the chapter will be on the reflections of the committee, the catering team, youth volunteers for the conference and some members of the scholar–activist team. The theoretical underpinnings and concepts that were considered at the beginning of the process will be reflected on in relation to the process and the progress in the village during this time period. These include concepts, such as development, participatory action research, an asset-based and community-driven (ABCD) process and the politics of knowledge. The reflections are based on reports and reflections at various points but mostly on reflections after the conference that was held in the village in

September 2018. These reflections were stimulated by the series of 60 photographs documenting various processes and achievements over a span of 4 years.

Background

Mji's[1] PhD thesis had attracted the attention of younger researchers who were keen to have an in-depth study on the different aspects of her thesis, such as education, spirituality, community engagement and traditional healing in the form of further PhDs and Master's studies. These young academics joined the team in Xanase village with those who had started the process of exploring IHK in Khayelitsha, Cape Town. Although their studies would include other villages in Madwaleni, their orientation to the area began with an induction of translating Mji's[1] findings in Xanase.

Discussions had been taking place in the village with the community for a few years before 2014, but the main process of community engagement, which included the scholar–activist team and the community of Xanase, began with a 2-day workshop with the community mapping their demographics, their assets and dreams for the future. The scholar–activist team specifically applied an ABCD approach, as it was noticed in previous visits that the community viewed itself as having only deficits. From the time that some of the team first arrived prior to 2014, and started dialoguing with members of the community, all that was expressed was what they did not have and how the government was neglecting their needs. This narrative was the same as at the beginning of the workshop in 2014. What was expressed was that they had no fresh water, only water from rivers and springs that they shared with all the animals. They had no sanitation, no electricity and no preschools for young children, and the primary school was far away and children had to cross a river with no bridge to reach the school. When it rained, the river was too dangerous for young children to cross and therefore they missed many days of schooling during the rainy season. This deficit view

of their lives was substantiated by the recall of memories by one of the scholar–activist team:

> We had conversations with the community and a lot was shared. Youth of this community did not go further with education as schools were far. They raised facts that those who went to school were bullied by others as they are bringing English as another communication language and others had no idea of how to respond to English as communication medium. We had to address the community in their own language and explain difficult concepts in isiXhosa. (Undisclosed age, female, activist–scholar)

She continued by saying:

> Our major concern was access to health, education, shops, services in general as this community was forced to access services from other villages. These other villages were far and they had to walk long distances. Transport was a major challenge, as the roads were in a very bad situation. I never enjoyed the trip to the village as it had so many potholes and unevenness. The community itself indicated that the roads are very bad and it gets worse when it rains and there is death in the village. They shared that they have to carry the body over the river and go over to another village for it to be kept in a mortuary. (Undisclosed age, female, activist–scholar)

The scholar–activist team felt that is was essential to change the paradigm and encourage the villagers to look at what they had, the individual and collective assets in the village, and build on those. This approach is known as an ABCD approach to development, which means achieving a complete paradigm shift from the more widely used needs assessment approach, which is usually deficit-based, and used by most community development and public health workers.[6,8] The ABCD approach was the first theoretical concept applied by the team after hearing of all the needs and what the villagers felt they did not have. The ABCD approach includes an appreciative inquiry approach and participatory action research. The other two theoretical underpinnings were regarding the politics of knowledge[2] and looking at an alternative view on development, which was more aligned with the ABCD approach, as expressed by Julius Nyerere[9]:

> Development brings freedom, provided it is development of people. But people cannot be developed; they can only develop themselves. For a while; it is possible for an outsider to build a person's house, but an outsider cannot give the person pride and self-confidence as human beings. Those things people have to create for themselves by their own actions. They develop themselves by what they do, they develop themselves by making decisions, increasing their knowledge and ability and by their full participation as equals-in the life of the community they live in [...]. (p. 2)

These concepts and theoretical underpinnings will be discussed further, later in the chapter.

Beginning of the process of community engagement

The first major workshop was facilitated by five members of the scholar–activist team and was attended by approximately 40–50 community members spanning all age groups in December 2014. The workshop began in a plenary, but the facilitators soon observed that only certain members spoke in the bigger group, mainly the men and a few older women. The youth and most of the younger women were silent. What was interesting was that in this patriarchal society, the young men were the quietest of all. The participants were then split up into six groups: The youth were split into young women and men, the middle-aged group into men and women and the old women (see Figure 13.1) and men formed their own groups.

In the groups, they all discussed what assets and skills they had and what their dreams were for the future. When the groups came together, the discussions from the groups were pooled, and from their dreams for the future, some plans were prioritised. There were plans to raise chickens, start a communal garden, explore spring protection, start a cultural centre and cultural tourism, and initiate an early childhood project for preschool children. The three projects that were pursued in the end were the exploration for clean water supplies and sanitation, the

Source: Photograph taken by Melanie Alperstein, on 12 October 2014, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.1: Older women's group with the facilitator.

building of rondavels for cultural tourism as well as the cultural centre and an early childhood project.

The Xanase Community Development Committee (Figure 13.2) was elected at the end of the workshop and consisted of office bearers: A chairperson, secretary and treasurer and four members from the community who were to lead the different projects. At this stage, there was no constitution for the project. This was developed by the committee and the other community members when funding became available, and a constitution was needed to open a bank account.

Water and sanitation project

In relation to acquiring clean water supplies, one of the scholar–activist teams had previously worked in the former Transkei in a Village Development Project and had acquired assistance from what was then the Transkei Appropriate Technology Unit (TATU). It was a parastatal that operated as a NGO, with its head office

Source: Photograph taken by Melanie Alperstein, on 21 August 2015, at Payne's Farm, Mthatha, published with permission from Melanie Alperstein.

FIGURE 13.2: Xanase Community Development Committee with the author of the book.

in Mthatha. Pursuing this previous resource, the team discovered that TATU was now part of the Eastern Cape Department of Rural Development and Agrarian Reform (RUDAR). We managed to arrange for field workers to visit the community and discuss how clean water could be acquired and how they could assist. This was quite a long process as the annual budget had been used up, but Xanase's needs were budgeted for in the next annual budget, and in 2016 water tanks were supplied and the department assisted with building bases and connecting the tanks on rondavels with zinc roofs to drainage gutters. Although the 20 tanks were not enough for every homestead, at least two homesteads close to each other shared a tank and this also promoted sharing and cooperation in the village. Some homesteads already had their own tanks, and this arrangement increased the collective gathering of clean water close to the homes. This gave some hope to the community and their confidence was boosted as they started to realise that they had

the ability to make things happen. Shortly before the tanks arrived, the municipality also installed VIPs for each household. The community mentioned that they were now becoming equal to other villages.

Focus on the young children of Xanase

The community was concerned that children below the school-going age had no preschool and were interested in starting an ECD project. Early childhood development refers to a comprehensive approach to policies and programmes for children from birth to 8 years of age, their parents and caregivers.[10] Its purpose is to protect the child's rights to develop his or her full cognitive, emotional, social, spiritual and physical potential, and the approach promotes and protects the rights of young children for survival, growth and development.[10]

At the initial workshop in 2014, a building was identified for the preschool children and a dynamic young woman who loves children volunteered to start the programme. The ECD project has continued ever since for 4 hours each week day, with a facilitator and assistant, although it has experienced some problems such as payment for facilitators, the migrant labour system and a building for some of the activities of the ECD project.

Children aged from 3 to 5 years gather for activities, such as playing, singing, reciting and writing (see Figure 13.3). An agreement has been made that each household, whether or not their children attend the preschool project, pay R30 per month for the project. Seven community members have volunteered to form a committee (see Figure 13.4). They are responsible, amongst other things, for collecting the fees and paying the facilitator and her assistant. Not everyone is paying, and as a result, the facilitator and her assistant have not been paid regularly. At some stage, the assistant could not continue, and this left only the main facilitator. There is a process in place to find a new assistant.

Source: Photograph taken by Melanie Alperstein, on 12 July 2017, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.3: Preschool children's outside activities.

Source: Photograph taken by Melanie Alperstein, on 26 April 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.4: An ECD facilitator and committee member and scholar–activist in a rondavel discussing the filing system of the ECD project.

Another challenge for the project relates to the migrant labour system and the fact that most fathers are in Johannesburg and the children along with their mothers visit their fathers for extended periods of time, thereby missing out on the classes. The facilitator also had to visit her brothers in Cape Town, and without an assistant, the preschool did not function during her absence. The building that was being used for the ECD activities was vandalised in the meantime. Stones were pelted breaking the window panes, so the secretary of the project committee offered to host the children in a new house while a new ECD centre is being built. A site has been identified for a new building, and bricks have been made by the community. Lately, after one of our visits, it was reported that the children had not been going to school as the facilitator had not been paid for some time and was looking for work elsewhere. This situation has been temporarily resolved by a small donation from an individual who was looking to support an ECD project, and the facilitator has therefore been paid for most of 2018. During a dialogue in a community meeting, a different approach has been adopted in the ECD project, whereby the preschool children visit homes in the community and learn about the indigenous ways of the *Bomvana*. This is explained later in this chapter.

Progress of the building of the cultural centre

The building of the three rondavels intended to host visitors has been completed but still needs to be furnished (see Figure 13.5 and Figure 13.6, illustrating indigenous was of preparing and transporting rafters to the building site, and Figure 13.7 and Figure 13.8 showing the progress of building the rondavels to completion). The foundation of the cultural centre has been completed (see Figure 13.9), and the walls were built halfway, but, unfortunately, a heavy storm destroyed them. Because of the position of the centre at the top of the hill just above the ocean, it is subjected to heavy winds and rain, and a plurality of

Source: Photograph taken by Melanie Alperstein, on 04 July 2016, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.5: Wood from the local forest being stripped for use as rafters for the roofs of the rondavels, illustrating indigenous ways of building.

Source: Photograph taken by Melanie Alperstein, on 04 July 2016, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.6: Indigenous ways of transporting the rafters for approximately 2 km.

Source: Photograph taken by Melanie Alperstein, on 15 November 2016, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.7: Rondavels half completed.

Source: Photograph taken by Melanie Alperstein, on 05 July 2017, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.8: Rondavel completed with paint and drawings – Local artistry.

Source: Photograph taken by Melanie Alperstein, on 05 July 2017, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.9: Foundation of the cultural centre.

knowledges for the appropriate building materials may need to be considered. Holes have been dug for two VIP latrines. Soil has been turned for a garden and seeds have been planted. Fencing to protect the garden and the rondavels from roaming animals is in the process of being erected.

A decision has been made by the committee to utilise the three rondavels for the activities of the cultural centre, while the building of the cultural centre is being completed. These rondavels were initially planned to accommodate guests for the project and, to a lesser extent, some holiday makers. Presently, the plan for the rondavels is to use one as a sleeping area for visitors. Initially, once the toilets are completed and the rondavel is furnished, it will accommodate the project team members based in Cape Town when they come visiting. A second one is to be used in the interim as a kitchen for meetings and visitors, and the third is presently being used for the ECD project and could be used for meetings outside of the 4 hours in the morning when it is used for ECD activities (see Figure 13.10). The plan is to

Source: Photograph taken by Melanie Alperstein, on 26 April 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.10: Early childhood development facilitator sitting in the rondavel now hosting the project.

complete the building of the cultural centre before the summer rains begin. Once the building is completed, it will accommodate the administrative functions, such as meetings, training for establishing and running of the cultural village, with the possibility of including general computer training with a view of establishing an appropriate form of 'Internet café'. Considerations of where computers will come from and from where electricity or other forms of more sustainable renewable energy sources, such as solar, wind and water energy, will be sourced are still under discussion and exploration.

Rationale for the chapter

The intention of the photo-documentation over the years was to use those images and the reflections of the community and the scholar–activist team and, together with the Xanase community, develop a popular education document to share with other communities of the process they have gone through,

the challenges experienced and the achievements accomplished. As community engagement work is not generally easy, the photographs have also been useful as a reminder of how we got started and the milestones achieved. This helps the Xanase committee on difficult days when challenges sometimes loom high and one forgets how we started and what has been achieved. When this book was proposed, it was decided that this process would also be appropriate as a chapter in the book.

Theoretical underpinnings and concepts that direct the arguments that drive the chapter

As mentioned earlier, the theoretical underpinnings adopted by the scholar–activist team were the ABCD approach, which includes an appreciative inquiry approach and participatory action research; the politics of knowledge; and an alternative perspective on development, as expressed by Julius Nyerere, that people have to develop themselves.[6,8,9]

Most of the scholar–activist team have been schooled in the needs-based approach, which is often a top–down approach, with experts identifying the needs in a deficit manner, focussing on the problems and disabilities. The community is largely seen as a consumer or beneficiary of their services and dependency is sometimes encouraged, even if unconsciously or unintentionally. The ABCD approach, on the other hand, encourages a bottom-up approach, identifying assets, strengths, gifts and abilities in the community. The community is seen as a producer of services and having the relevant knowledge to lead the process. The ABCD approach is a process and can take a long time.[6,8] Ultimately, the practice encourages a community development approach, similar to that proposed by Nyerere,[9] where community members take responsibility for conceptualising, planning and directing a process. Other participants, usually from the outside, are consulted on the terms set by the community and partnerships

may develop from this engagement. In addition, whether in Africa, Austro-Asia or Latin America, there is a need for new development models that are based on the indigenous philosophies of the indigenous peoples; where development does not focus on economic development and consumerism of goods but on respect for mother earth and a changed relationship with nature; where human beings are not at the centre of the universe but are at one with the earth, animals and plants.[2,4,5] From the health services, a change is needed from the hegemonic focus on curing disease and pathologising everything, including pregnancy and childbirth, to a caring for life perspective and caring beyond the health system to nature, the social and environmental determinants of health, sovereignty, solidarity, sustainability, gender equality and difference.[11] For the professionalisation and institutionalisation of knowledge, where limited knowledge is shared and money is made from knowledge, as it is in this neoliberal era, the politics of knowledge is strongly related to the political economy of knowledge. Power exists even at the level of knowledge, at all levels and in all disciplines. Where certain dominant forms of knowledge are withheld and other indigenous forms are dismissed, it is the poor and marginalised that are disempowered. 'If we all know everything, we know. We don't depend on anyone'.[2]

To change the status quo, all need to become aware and recognise and respect pluralism. Indigenous people from the Philippines remarked that, '[t]he forest for us is like your supermarket or pharmacy for you'. It is never either/or, but always much more complex. Sometimes we have to go forwards, sometimes backwards and sometimes even sideways (personal communication, April 2008, key informant Chieftain Tinky-Penny from the 18 villages of Gusi, discussing the 'backward and forward movement').[2] For development to take place, there is a need to deconstruct and reconstruct what has been lost through colonisation; decolonise knowledge, especially systems of power. Dominant systems do not always have solutions and at present are destroying the planet.[2,4,5]

Critical emerging knowledge

Critical emerging knowledge is based mainly on the reflections after the conference in September 2018, but there were moments of critical emerging knowledge and paradigm shifts taking place, even during earlier discussions on the progress of the projects.

Moments of critical knowledge emerging prior to the September 2018 post-conference reflections

During dialogue with the project committee

A moment that stood out was during one of the visits by some members of the scholar–activist team while in the process of trying to convey some of the project intentions to committee members. During the analysis and discussion with the committee about the quotation they had prepared for furnishing the rondavels, the question that was raised was whether some of the things they intended to purchase could be made from natural, locally available resources, for example, beds, tables and chairs that could be made from wood. They could design and make things using local skills, for example, grass curtains and mats. Reflecting their culture through their own creativity will enhance the intention of the project. During this discussion, the secretary of the project committee had a major realisation and paradigm shift, and exclaimed, '[n]ow I understand that civilisation is not something that is outside, it comes from within'.

She was so excited that it was very difficult to get her to stop talking during the rest of the meeting. She wanted to stay with that idea and further unlock it and continue her exploration of this important idea. This pointed to the need for many more opportunities for this kind of dialogue. There was no opportunity to explore the topic with other members of the committee as time is always a problem with these time-limited visits. Instead, we made a note of this comment and when we were planning for the

next cycle of activities for the project, we decided that we would continue exploring this in the *imbizos* – chief's meetings – going back to who the *AmaBomvana* were before modernity entered their quiet existence and what civilisation is still lying dormant within, and what processes are the community suggesting to bring this civilisation to the surface. This process began when discussing what children should be learning in the ECD project.

During a general community meeting

While exploring and discussing the possibility of the preschool children visiting different homesteads where they could learn indigenous practices in different homes and be told stories by elderly members of the homestead, another similar moment occurred during an *Imbizo* in 2017. One man remarked that he suddenly realised that they expected the youth to know these indigenous practices, but they had never taught them. This started a lively discussion of what young children could be taught, and this plan was implemented from then onwards. Following this approach, children can learn from an early age what it means to be a *Bomvana*, their ways of doing and being, their rituals, their history and culture, their civilisation. This can all be learnt from the elders in the homes and hopefully documented by the ECD facilitator assisted by other youth. If the knowledge of the elderly is not documented, it could disappear.

Critical emerging knowledge from the reflections after the conference

The day after the conference ended, members of the scholar–activist team and members of the Xanase Community Development Committee, as well as the catering team and youth volunteers, reflected not only on the conference but also on the journey from the first workshop in December 2014. The 60 photographs were the 'codes' used to initiate the reflection on past events and achievements. These photographs were put

up on the walls of the hut where all our meetings took place (and where the scholar–activist team slept at night). The photographs were moved to the conference venue for the 2 days of the conference. From the reflections of the community members, a number of common themes arose. The first being, 'progress over time: from fear to pride and confidence'; the second being, 'what we have achieved'; and the third being, 'meaning drawn from the photographs'.

Progress over time: From fear to pride and confidence

The villagers expressed that in the beginning, everything felt like a mess. They did not have trust in each other. They were afraid, but over time they progressed, working together and building trust. In the end, they managed to host this huge conference with confidence and pride; '[w]e didn't trust. We were afraid. Then in the middle of developing came with a huge conference. It killed us, but we achieved something huge' (Committee member 1, female, 20 September 2018).

What we have achieved

The photographs helped to remind the committee and others what they had achieved over the years. They noticed that people were very interested in the photographs and they could use the photographs as evidence to explain where they had started, how they had progressed and what they had achieved and that they had done it all themselves; '[s]hows us where we started and where we are going. Some evidence and can be seen by others [...] and all doing ourselves' (Committee member 2, female, 20 September 2018).

The three main achievements highlighted were the rondavels, the ECD project and all culminating in the conference.

The conference

The pride of progress and achievement was hosting and organising the logistics for the conference.

The first conference, as mentioned before, was held in 2016 at the DWF (see figure 13.11). This is an NGO built on the legacy of Donald Woods, editor of the Daily Dispatch newspaper in East London, South Africa, and friend of Steven Bantu Biko, an activist, assassinated by the apartheid government of South Africa in 1977. Donald Woods and his family fled the country after Biko's murder in detention as the family was harassed constantly by the security police and Donald Woods was under house arrest. The land the DWF is built on belonged to Woods' parents. Dillon Woods, son of Donald and Wendy Woods, is the chief executive officer of the NGO. The property is extensive with many rooms for visitors as well as a well-stocked library and lecture theatre. However, it is very well-secured by fencing, which makes the community feel excluded even if they are welcome to use the facilities for meetings and workshops. Many felt that they would be more comfortable if the next conference was held in a community hall, organised by the community.

They expressed that even though the conference at the DWF in 2016 was good, the conference organised and hosted by the

Source: Photograph taken by Melanie Alperstein, on 01 July 2016, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.11: The conference at the DWF in 2016.

Xanase village was a 'very lovely conference' (see Figure 13.12 a and b and Figure 13.13). Evidence of the success of the conference was that the paramount chieftainess of the area stayed till the end of the conference. This surprised everyone as she normally

Source: (a & b) Photographs taken by Melanie Alperstein, on 19 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.12: (a & b) The September 2018 conference – contrasting vibrancy with traditional healers playing a major role.

Source: Photograph taken by Melanie Alperstein, on 19 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.13: The full hall of the September 2018 conference with traditional wall hangings.

never stayed long at events. She left the conference in 2016 at the DWF soon after she had addressed the conference. 'We were congratulated that Nobangile stayed for the whole conference, not at DWF' (Committee member 3, female, 20 September 2018).

Although it was stated after the conference held at the DWF that the next conference should be in the village, they initially doubted their ability when it was about to become a reality. One remarked that they had sleepless nights.

The youth volunteers who were recruited stated that they feared that they would not succeed. One youth member said that it was for the first time that she was involved in an event from scratch and she feared that it would not be successful, stating that 'I had fear. The conference was huge and I had fear if all people would be fed' (Youth volunteer 1, female, 20 September 2018).

This fear was soon allayed when everyone received tea and food.

It was acknowledged that the food was appreciated by all. There were phone calls for 'take-aways' and invitations to cater at

Source: Photograph taken by Melanie Alperstein, on 18 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.14: The catering team busy preparing the food.

events for the chiefs in the future. This boosted the confidence of the catering team (see Figure 13.14). 'We cooked to the extent that we are invited to cook for the chiefs. They only want Xanase to cook for them' (Catering team member 1, female, 20 September 2018).

All then mentioned how everyone worked together and united to make a success of the conference:

> There are people and they will help. Started to design the menu and the list. It was everybody's business [...] cleaning decorating and the traditional things looked wonderful [...] the whole design, they cooked bread, mixed drink instead of fizzy, and especially the grass things holding fruit and those traditional things hanging on the walls [...] (Committee member 4, female, 20 September 2018)

□ The Early Childhood Development project

Apart from the conference, the next achievement they identified was establishing the ECD project. They opined that through the ECD project, the children were progressing well, and it felt good to see them move on to a bigger school; 'the children have been

progressing well. Good to see those who moved to bigger school' (Committee member 2, undisclosed gender, unknown date).

The three rondavels

The last achievement highlighted was revisiting why the three rondavels had been built. With the visit by the international students, there was a new impetus for getting the cultural tourism going. As there was a strong interest in cultural tourism and the ECD project during the initial workshop, a visit was organised to Bulungula in 2015 (see Figure 13.15), which has both an established cultural tourism and ECD project.

After the visit, the committee decided to build the three rondavels at the site where the cultural centre will also be built. These three rondavels were completed in 2017, but they still need furnishing. Apart from the members of the wider Madwaleni community, the conference was also attended by students from Washington University in Seattle, who were staying at the DWF in Hobeni village. The committee realised that cultural tourism could really happen and bring money into the village, as well as

Source: Photograph taken by Melanie Alperstein, on 09 April 2015, at the Bulungula village, published with permission from Melanie Alperstein.

FIGURE 13.15: The Xanase team visiting Bulungula.

Source: (a & b) Photographs taken by Melanie Alperstein, on 13 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.16: (a & b) Demonstrating brick-making to international students – the whole process from the beginning to the final product.

be an opportunity to share their way of life with others. The students had visited a few days earlier and had learnt how to make traditional mud bricks (see Figure 13.16 a & b), were shown how grass was harvested and used to thatch roofs of rondavels and make various traditional mats, blinds and other household goods. They were also entertained by the children with traditional songs, dance and poetry as seen in Figure 13.17.

Source: Photograph taken by Melanie Alperstein, on 13 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.17: Children confidently entertaining students with traditional poetry and dance.

The students had also gone for a walk on the beach, accompanied by some of the Xanase community members, where they were excited by the discovery of an abundance of seashells (see Figure 13.18 and Figure 13.19)

The community members realised what they had to offer and the future possibilities that could be mutually beneficial to them and the visitors. One expressed that they could stay in their homes where they would be safe, and another opined that they could also stay in the rondavels as they would also be safe and were close to the sea. In both instances, everyone would benefit:

> We were wishing they were sleeping in our homes. We could be counting money, but it was taken by the DWF. We have no crime. That is why the area is not fenced. We are not people who harm each other. (Committee member 5, male, 20 September 2018)

> What is nice about these rondavels. They can host international visitors. They are close to the sea and the students want to see the sea and were excited to see all the sea shells, asking how much to pay for them as they picked them up. And we said they were free. (Committee member 4, female, 20 September 2018)

Source: Photograph taken by Melanie Alperstein, on 13 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.18: The pristine beach below the cultural centre and the three rondavels.

Source: Photograph taken by Ntombekhaya Tshabalala, on 13 September 2018, at the Xanase village, published with permission from Ntombekhaya Tshabalala.

FIGURE 13.19: Students enjoying the beach.

☐ Meaning drawn from the photographs

All expressed that the photographs had helped them to see themselves, from the very first workshop, as to where they had come from, what they had achieved, some of the challenges they had faced and where they needed to go in the future. They could acknowledge that they had moved from feeling they had nothing, to where they are now, being proud of themselves, what they have in their community and confidence to build on what they already have:

> The pictures were very nice. We are learning. We have hardly seen pictures like that. We see ourselves. We are so happy to see us and children and Xanase in the pictures. At a glance, they seemed international, but looking again closely, it was all Xanase people. (Youth volunteer 2, female, 20 September 2018)

> The pictures also helped to unpack some problems, showed points of unity and division in the community. Those many groups that were supposed to drive projects – not as united as we were. When building started and we were united, and then at times divided. As we are progressing, then came the savings group and that seems to be a uniting factor. (Committee member 1, female, 20 September 2018)

> I must be called forward and disciplined when it needs to be and we must correct each other. I was very troubled by the slow movement of the cultural centre. It is a nucleus and needs to be done for example for international visitors. (ECD Committee member 1, female, 20 September 2018)

From the reflections of the community members, they acknowledged their progress and achievements, as well as concerns and lessons learnt. There was enthusiasm for going forward and mostly calls for working together and unity were expressed. They expressed that they 'must unite and work with one spirit'. To continue going forward, they needed to 'continue progressing and listening to each other'. They felt that if they had not been united, and if 'the vision and mission were not the same', it would not have worked in the past, and this needs to continue into the future. In addition, there was a suggestion that there needed to be commitment and discipline to keep the work going

forward, and a concern was expressed that sometimes progress is slow and that the photographs are a reminder and motivator to move forward.

Reflections of the scholar–activist team

Four of the team members were present at the conference and at the reflection afterwards. Three of the four had also participated in the first workshop and had returned for visits throughout the period from December 2014 to September 2018. The fourth team member joined about 2 years after the first workshop. The reflections of the scholar–activist team largely echoed those of the community.

They reiterated 'growth and development' and 'progress over time'. All complimented the community on the success of the conference:

> I was full of joy to see what was planned. (Scholar–activist 2, female, 20 September 2018)

> When I saw the hanging of traditional arts and crafts in the hall and the chairs being prepared, I could see the energy and that people were able to do it perfectly (see Figure 13.20). (Scholar–activist 3, female, 20 September 2018)

All agreed that working together and unity ensured the success of the project in general, progressing over the years and the conference being a success. Some members of the committee had expressed that they felt that they were not always united. One member of the scholar–activist team stated that perhaps they felt that way at times, but they would not have achieved what they had so far without unity and working together with all the diversely skilled people in the community.

The conference had also attracted the youth, and the team encouraged them to keep the momentum and harness the interest shown by the youth. Even the young children from the ECD project and from school had played their part and conveyed their praise by singing and dancing excellently and with great confidence (see Figure 13.21).

Source: Photograph taken by Melanie Alperstein, on 19 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.20: The hall during the conference with traditional hangings on the wall.

Source: Photograph taken by Melanie Alperstein, on 09 September 2018, at the Xanase village, published with permission from Melanie Alperstein.

FIGURE 13.21: First rehearsal in the hut with children who were very shy, but performed confidently for the students and at the conference.

Future research

The future intention is to include the reflections from the broader community, and in a participatory action research process, possibly through stories and poetry depicting their experience of the engagement. Using photo voice is also being considered as a possible methodology. There should be an annual event as a participatory action research process as the project progresses. Because the ECD project has been the most sustained project, and possibly one of the most crucial ones, there are many questions that are also related to the functioning of the ECD project and some of the challenges related to early childhood and community development that need to be reflected upon. This may help the community resolve tensions and contradictions regarding the response and future of the education of their children.

Examples of questions and reflections that could be pursued in future community dialogues include the following:

- According to the committee, why, and by whom, were the windows of the rondavel that was hosting the children broken? This question emerged as a result of the breaking of the windows of the rondavel that was initially used for the ECD project. No one seems to know what happened and who broke the windows.
- Which children are not coming to the project, and why? There was inconsistency in the attendance of the children.
- Contradiction on what is seen as schooling: A critical question that emerged as we were trying to apprise the community members of the need for the children to visit and learn from their homes, as well as storytelling from the older community members. There was also a deeper underlying issue similar to the secretary's perception that civilisation comes from within: We had a perception that there was a lot of teaching and learning that was happening in the households of the Xanase community. Parents first needed to be affirmed of this fact and secondly check with regard to our ECD programme as to how it can be used as a start for the younger generation to start appreciating their own home-grown knowledge and civilisation.

- Some of the Xanase community members, especially the younger generation that have not participated in the present schooling system, challenge people who speak English and appear to be rebellious and angry towards these cultural changes that they perceive to be excluding their knowledge and experiences. We noted this positioning within a historical perspective of who are the *AmaBomvana* – including how external agents entered their communities and the need to invest in the future in a reconciliatory model, which we hoped will ultimately be placed in a space whereby we could apply the backward and forward movement suggested by one of the chieftains during data collection of the PhD study.
- It appears that the schooling system is in contradiction with their culture. We were quite aware of this from the previous PhD study and already there was a follow-up study that intended to do a deeper exploration of this issue.
- Issues of a culture in transition and contradictions are emerging with a section of village dwellers resisting the new order, while others do not want to be left behind – hence the cry for their young children who are not going to school.
- Are there opportunities to open doors for dialogue and for all voices to be heard whereby these contradictions could facilitate a process of reconciliation and transformation, including the way forward? In our thinking, we thought the *Imbizo* would be a good space to address all these contradictions with the community participating and making informed choices about the way forward.

Concluding statement

In Chapter 9, Mji explains the models or schools of thought that formed the framework that influenced the way in which PhD findings were translated into action. These are 'social capital', 'asset approach' and 'horizontal learning', otherwise referred to as 'recognition of prior learning' and 'community participation'. This chapter elaborated on the asset-based community-driven development approach, which aligned with an alternative approach to development as proposed by a great African scholar,

Julius Nyerere. The politics of knowledge refers to how hegemonic forms of knowledge are valued more than prior knowledge of the indigenous people. Through the process of engagement, and based on the reflections, social capital has been built, although fragile at times. Prior knowledge was drawn on and used in organising the conference, building the rondavels and in the ECD project. The community, in general, participated in all activities. The process has its challenges but is ongoing. The conference and the visit by international students reinforced the importance of acknowledging and showcasing indigenous knowledge, skills and ways of doing and being.

The photo-documentation appeared to assist greatly as 'codes' for reflection. There was not enough time to question deeper some of the reflections, and this needs to be done in the future. This process should be continued, and the community should be included in a workshop on the ABCD approach to community development. The indigenous knowledge of ways of knowing, being and doing should be documented in a popular education style publication, written by the community in their mother tongue and shared with surrounding villages and further. For an alternative approach to life and development, we need to:

Decolonise the thought

De-medicate life

De-commodify

De-industrialise

Dignify life.[11]

As this book comes to an end, we would like to draw wisdom from the secretary of the Xanase who had a heated discussion during a community engagement meeting that was focussing on using their own natural resources for creating furniture for their cultural centre – we saw light shining in her eyes and then she said:

'Now I know, civilisation starts from within' – A gentle reminder for external agents!

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Chapter 1

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Index

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The author, Gubela Mji, presents compelling testimony to the strains and fragile victories of indigenous health practices confronted with hegemonic biomedicine and the expansion of Western modernity, both riding on the coattails of a global racist, patriarchal, Christian-centric and capitalist agenda. Yet there is cause for hope. After all, even without limbs, walking must continue. The backbone enabling this 'walk without limbs' is the group of elite, older Xhosa women whom the author aptly calls 'indigenous health scholars'. The timing of this book, with South Africa geared towards the roll-out of the National Health Insurance, is particularly fitting.

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Based on empirical evidence gathered from fieldwork, this book brings a fresh perspective on the integration of indigenous knowledge systems in the management of primary health care services in a context by encouraging community-based, health-seeking behaviour. The importance of indigenous knowledge in empowering local communities is increasingly becoming recognised. Indigenous knowledge systems have been neglected as a factor in sustainable development due to various factors. Overcrowding of primary care services, such as community health centres in rural communities, can be addressed through recognising and integrating indigenous knowledge in the current health model and health care policy formulation.

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