Exploring and Identifying the Indigenous Healers of Madwaleni and their Relationship with Ethnobotany and Healthcare

by
Thandokazi May

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Supervisor: Dr Gubela Mji

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DECLARATION

By submitting this research report, I, Thandokazi May, declare that the entirety of the work contained therein is my own, original work, that I am the owner of the copyright thereof (unless to the extent explicitly otherwise stated) and that I have not previously in its entirety or in part submitted it for obtaining any qualification.

Date: April 2019

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ABSTRACT

Rationale: The use of indigenous medicine is widely known in South Africa. In fact, it is estimated that 80-85% of black South Africans consult with indigenous healers in both rural and urban communities (Moshabela, et al., 2016). Despite increased academic interest in indigenous health knowledge (IHK) in the country, there is still interest in studies that are aimed at documenting the indigenous practitioners as well as their herbs and plants. Suggestions have been made to fill this knowledge gap by conducting ethnobotanical surveys of the plants used by indigenous healers as well as to identify who are these healers that use these plants.

Aim and Objectives: The main aim and objective of this study was to explore and identify the indigenous healers of the Madwaleni, including the illnesses these healers manage, and which herbs are used to treat each illness. Other objectives were to: catalogue the ethnobotanical diversity used by these healers, and to identify the precise botanical environment that these herbs grow as well as the relationship these healers have with these environments. Lastly, the study explores the relationship between indigenous healers and the biomedical health care system in the area.

Method: This is a descriptive, ethnographic study that used qualitative methods of data collection. The data was collected through participant observation, where participants took part in interviews and Focus Group Discussions (FGDs). There were 37 participants and key stakeholders, 30 being practitioners of indigenous medicine, 5 being biomedical health professionals, and 2 being traditional leaders. Both in-depth interviews and FGDs were used to collect data, totalling up to 6 interviews and 15 FGDs. Life stories were documented as part of exploring methods that could be used in the reconciliation process. The plants used by the indigenous healers of the area were documented transcriptionally and photographically.

Findings:

- The indigenous healers of Madwaleni can be categorized in five categories: (1) amaGqirha (indigenous doctors) and (2) amaXhwele (herbalists), (3) elite older Xhosa women and (4) amaTola (older elite men), and (5) abaThandazeli (faith healers). Intersectionality and partnerships between these groups of healers was welcomed and encouraged, although some unresolved tensions exist between the healers due differences in philosophy and practice.
- The relationships between the individual, the community, the natural environment and the ancestral spirits all play a pivotal role in maintaining health in Madwaleni. Therefore, health is attained when the complete balance between mind, body and soul is achieved through the maintenance of solid relationships between all members of society, including the ancestors and the natural environment.

- When sickness results because of rifts in these relationships, indigenous medicinal plants must be administered to treat the illness and to regain the normal state of health. These plants are believed to be imbued with the spiritually healing powers of the natural environments in which they grow. Consequently, indigenous amaBomvana medicines have not only a healing function, but also have an apotropaic spiritually protective function.
- Tensions continue to dominate the landscape between indigenous health knowledge and Western knowledge in Madwaleni. Biomedical professionals in the area cite the lack of empirical evidence for the pharmacological functions of indigenous medicines as the reason behind their refusal to accept IHK as a valid health system.

Conclusion: Considering the cultural understanding of well-being and the determinants of health, the amaBomvana prefer to utilize diverse health management strategies when it comes to managing and treating illness. The health strategies of the amaBomvana people are exceptional and have the potential to help unlock some of the medical challenges of the modern world. The existence and endurance of various indigenous healers and their IHK strategies in the face of the threat of biomedicine is attestation to this. There exists a lot of unresolved tension between the various groups of healers in the area, due to differences in ethnomedical practice and philosophy. Before a partnership can be formed with the biomedical field, the indigenous healers themselves would need to share and acknowledge each other without taking any position of superiority over each other. The unresolved relationship between biomedicine and the indigenous health system creates spaces of confusion for the patients of Madwaleni, often resulting in bad health decision making and mismanagement of disease. A reconciliation process model is recommended by the study in order to repair this.

Keywords: Indigenous knowledge systems (IKS); indigenous health knowledge (IHK); amaBomvana; reconciliation between biomedicine and indigenous medicine; medical pluralism

OPSOMMING

Rationale: Die gebruik van inheemse medikasie is alombekend in Suid Afrika. Feitlik, daar word voorspel dat 80-85% swart Suid Afrikaners graag inheemse geneers in beide stedelike en landelike gemeenskappe (Moshabela, et al., 2016). Ten spite van die akadiemiese belangstelling in inheeinse gesondheidskennis in die land, is daar ‘n belangstelling in terme van studies wat bedoel is om inheemse geneersers to document sowel as hul plante en kruie. Voorstelle was gemaak om die kennis gaaping hoe om etnobotaniese opnames van die plante wat gebruik deur inheemse genesers so wel as om te identifiseer wie hierdie genesers is wat hierdie plante gebruik.

Doelwette en Objektiewe: Die hoof-en objektiewe doel van hierdie studiewas om te verken en te identifiseer wie die inheemse genesers van die Madwaleni, insluitend die siektes wat hierdie genesers behartig, e nook watter kruie gebruik word om hierde siektes te behandel. Ander objektiewe was om etnobotanise diversiteit wat deur hierdie genesers gebruik word, te identifiseer en die presiese botaniese omgewing waar hierdie plante groei, die verhouding of verwantskap wat hierdie genesers het met die omgewings. Laastens die studie ontblood die verewantskap tussen inheemse genesers en die biomediese gesondheids sisteem in die area.

Metodie: Hierdie is ‘n beskrywende, etnographiese studie wat kwalitatiewe metodes van data wetenskap versameling. Hierdie data was versamel deur deelnemende observasie, waar deelnemers deelgeneem het in onderhoude en Fokus Groep Besprekinge (FGB). Daar was 37 deelnemers en sleutel aandeelhouers waarvan 30 praktisyne van inheemse medisyne was, en 5 biomediese gesondheids praktisyne en waarvan 2 tradisionale leirs was. Beide in-diepte onderhouse en FGB’s was gebruik om data te versamel, wat in total tot 6 onderhoude en 15 FGB’s was. Lewens verhale was gedokumenteer as deel van die bloodstelling-metodes wat kon genruik word in versoeningsprosesse. Die plante wat deur inheemse genesers gebruik was van daardie area was transkripsioneel en fotografies.

Bevindige:

- Die inheemse genesers van Madwaleni kan in 5 katagorie gedeel word: (1) amaGqirha (inheemse geneerhere) en (2) amaXhwele (kruie doktor), (3) elite ouer Xhosa vrouens en (4) amaTola (ouer elite mans) en (5) abaThandazeli (geloof geneeshere). Interdepartementele en venootskappe tussen hierdie groepe van geneerhere was verwelkom en gemotiveer, alhoewel sommige onopgeloste spanninge tussen hierdie genesers bestaan het as gevolg van die verkille in filosofie en praktyk.
- Die verhoudings tussen die individue, die gemeenskap, die natuurlike omgewing en die voorouerlike geeste het alles ‘n draaidende rol in die instadhoudings gesondheid in Madwaleni gespeel. Darrvoor, gesondheid was bereik wanneer die volle balans tussen die

brein, liggaam ensiel bereik was deur die instandhouding van soliede verwantskap tussen alle lede van die gemeenskap, insluitend die voorvardelike en die natuurlike omgewing.

- Waneer siektes verorsak word gevolg van die valley in hierdie verhoudings, inheemse mediese plante moet geadministreer word vir die behandeling van hierdie siekte en om ‘n normale gesondheidstoestand te herwin. Daar word geglo dat hierdie plante gevul word met geestelike genesings krag van die natuur omgewing van waarin hulle groei. Gevolglik, inheemse amaBomvana medikasie het nie net ‘n genesings funksie nie, maar het ook ‘n opotropiese geestelike beskermings funksie.
- Spanning het voordurend die landskap tussen inheemse gesondheids kennis en westelike kennis in Madwaleni gedomineeer. Biomediese professionele in die omgewing noem die gebrek van emporiese bewyse vir die farmakologiese funksies van inheemse medisyne as die rede agter hulle weieringnom Inheemse Gesondheids Kennis (IGK) as ‘n gedeldige gesondheid sisteem te aanvaan.

Gevolgtrekking: Oorwegend die kulturele verstaanbaarheid van gesondheid en die bepalings van gesondheid, die amaBomvana verkies om diversiele gesondheids bestuur te uteliseer wanneer dit kom by die bestuur en behandeling van gesondheid. Die gesondheid strategie van die amaBomvana gemeenskaap is uitsonderend en het die potensiaal om sommige van die medikasie uitgapings te ontdood van die mediese uitdagings van die modern wereld. Die bestaan en uithouvermoe van verskillende inheemse genesers en hulle Inheemse Gesondheids Kennis (IGK) strategie in die oe vir die behandeling van biomedikasie is ‘n verklaring van hierdie. Daar bestaan ‘n klamp onopgeloste spanning tussen verskullende groepe van genesers in die omgewing, as gevolg van verskille in etnomediese praktisyne en filosofie. Voordat ‘n verwantskap gevorm kan word met die biomediese veld, die inheemse genesers hulself benodig om mekaar te aanvaar en erken sonder om ‘n posisie van gesag oor mekaar te bewys. Die onopgeloste verhoudinge tussen biomedisyne en die inheemse gesondheids stelsel skep ‘n gaping van verwaring vir die pasiente van Madwaleni, lei tot swak gesondheids besluite en wanbestuur van siektes. ‘n Rehabiliterings proses modul, gesentreerde mediese pluralisme, is aangewys deur die studie om alles hierdie te herstel.

Sleutelwoorde: Inheemse Kennis Stelsels (IKS); inheemse gesondheids kennis (IGK); amaBomvana; herstelling tussen biomedisyne en inheemse medisyne; mediese pluralisme

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LIST OF ABBREVIATIONS

AHWs - aboriginal health workers

DWF – Donald Woods Foundation

FGD – focus group discussion

HIV – human immunodeficiency virus

IK - indigenous knowledge

IHK – indigenous health knowledge

IWGA – International Working Group on Indigenous Affairs

PHC – primary health care

TCM – traditional Chinese medicine

UN – United Nations

WHO – World Health Organization

CHAPTER 1

INTRODUCTION

1.1 Introduction of the study

The primary aim and focus of this Master's dissertation was to identify who the indigenous healers of Madwaleni are and to identify the exact illnesses these healers manage, and which herbs they use to treat each illness. Secondly, to present and catalogue the ethnobotanical diversity used by these healers, and to identify the precise botanical environment that these herbs grow as well as the relationship these healers have with these environments. Lastly, the study aimed to explore and present the relationship between indigenous healers of this area and their relationship with biomedical health care professionals of the 9 clinics and secondary hospital in this area. The study setting is in Elliotdale (eXorha in isiXhosa) an area of the Eastern Cape Province of South Africa loosely called Madwaleni because of the secondary hospital that give health services to the people of this area.

Chapter 1 will serve as the introduction chapter for this study. This chapter explores the background to this study, where some of the issues that have shaped the field of indigenous health in South Africa and abroad are explored and in what ways those issues have inspired this study. This chapter also explores the study setting and its population, as this is particularly important as it might possibly assist to shape the reader's understanding of the cultural beliefs that have shaped the indigenous health system of Madwaleni. In this chapter the points of motivation for conducting this study are given, and what contributions the investigator envisions this study will make to academia. A conceptual underpinning of the study objectives is explored in detail so as to provide theoretical support and explanation as to why these objectives were the chosen for this study, and importantly why it was important to structure them in the manner in which they are structured.

For the purpose of this study, the terms "biomedical practitioner/biomedical healthcare professional/biomedical health services" are used to refer to any Western trained medical professional, be it a doctor or nurse and the health service they render. The terms are used interchangeably as some literature citations use one or the other. Since this study is inspired by the findings of Mji (2013), the terms and descriptions Mji uses are also used in this study. Likewise, the terms "indigenous health practitioner/indigenous healer" refer to any health professional who has trained under the indigenous knowledge system of their culture which sometimes is classified as traditional healers and indigenous health (Mji, 2013).

1.2 Study setting

This study was conducted in Madwaleni, a rural community in the Eastern Cape Province of South Africa. Madwaleni is situated 81 km away from the city of Mthatha, and the closest town is Elliotdale. The most prominent cultural group in Madwaleni are the amaBomvana people. The area lies on the outskirts of the Dwesa-Cwebe Nature Reserve; a unique blend of coastal forest, winding rivers and open grassland that lies between the Mbashe and Xorha rivers and the Indian Ocean. The purpose of the Nature Reserve is to conserve the unique biodiversity of the coastal forests of this region (Tourism, 2018). The indigenous medicinal plants of Madwaleni are found in the Dwesa-Cwebe forest, on the banks of the Mbashe and Xorha rivers, and in valleys and fields all across Madwaleni.

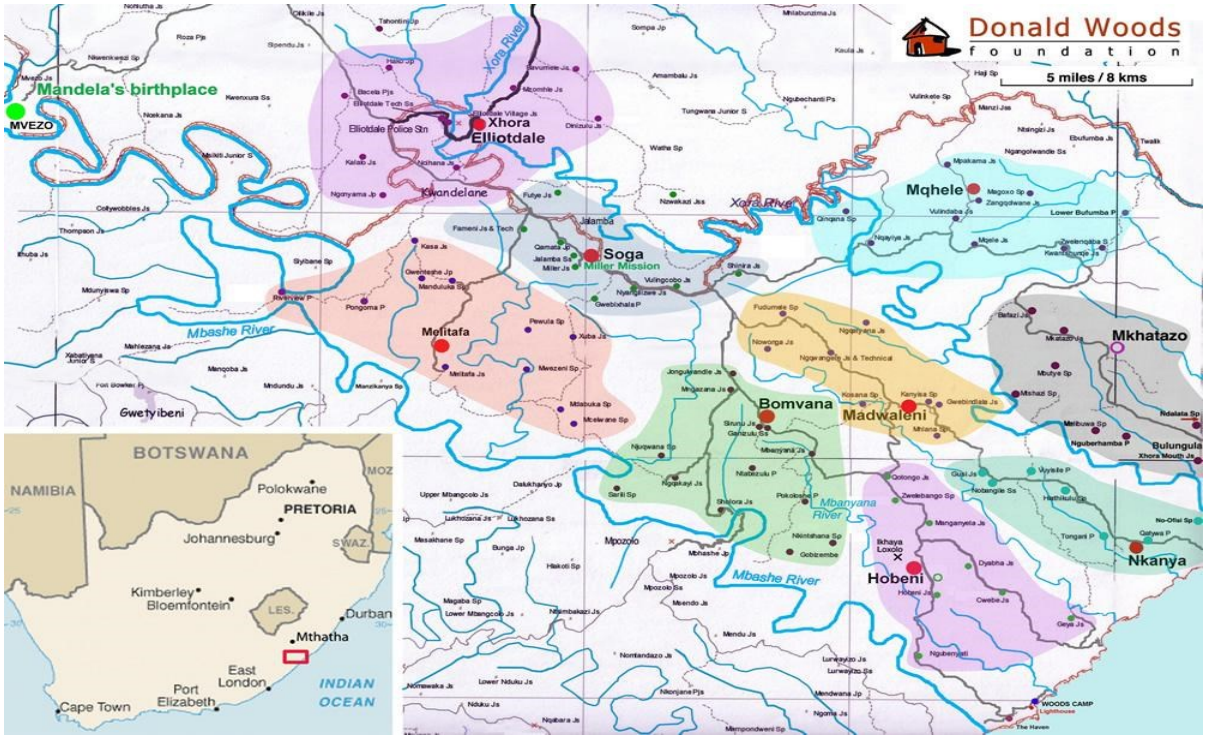


Figure 1: A map showing the 9 principalities of Madwaleni, a rural area of the Eastern Cape situated 81 km from the city of Mthatha. The red dots represent the embedded rural clinics of each of the 9 principalities operating in Madwaleni. Map courtesy of the Donald Woods Foundation.

Madwaleni boasts a large array of indigenous health practitioners who utilize indigenous health strategies to manage illness. The area also has a large secondary hospital and 9 clinics that are 0-35 km away from the hospital, which offer allopathic medical care for people of the area. Madwaleni is

an area with poor transport and accessibility to emergency medical services offered by the hospital and clinics is an issue of concern. In total there are 18 villages in the area of Madwaleni, all of which fall under 9 different principalities (namely Hobeni, Bomvana, Soga, Melithafa, Nkanya, Xhora, Madwaleni, Mkhatazo and Mqhele) which all lie directly on the Wild Coast region of the Eastern Cape. For this study, the 6 villages of Hobeni, Makhamezwe, Cwebe, Manganyela, Nkanya and Xorha were purposely chosen for this study, as some villages are closer to the hospital while some are further away.

1.2.1 Description of the study population; their health and religious belief systems

1.2.1.1 Ethnic background

The amaBomvana people of Madwaleni are part of the amaXhosa ethnic group of South Africa. Ethnically, the amaXhosa people are a part of the Bantu population group of Africa (Winkel, 2010). They are further divided into smaller ethnic sub-groups with related but divergent heritages and customs. Thes sub-groups found around the Elliotdale area are the Bhaca, Bomvana, Mfengu, Mpondo, Mpondomise, Thembu, Xesibe and Xhosa peoples (Foster, 1967). The amaXhosa people of South Africa refer to their native language as *isi*Xhosa. Just like many of the other Xhosa sub-groups, the amaBomvana culture is patriarchal, with men usually taking the position of heads of their households and women and children being expected to comply with their authority. The amaBomvana society has a set of rules and guidelines that govern community life. One of those rules include the custom of *ukuhlonipha*. The custom of *ukuhlonipha* is based around the cultural belief that women and girls are to pay respect to men within the family and in the community at all times (Foster, 1967). *Ukuhlonipha* includes guidelines on how a female should dress and talk in spaces where men are present, which often means she has to take an acquiescent role.

1.2.1.2 Indigenous religious belief system

The amaBomvana, as well as the rest of the amaXhosa people, have their own organized indigenous religious belief system. This religious belief system places *Qamata* (the Creator) at the centre of creation. It is believed that *Qamata* created both the physical and the spiritual worlds (Mtuze, 2004). When one dies, their spirit passes on to the spirit world and that person becomes an ancestor. The ancestors look after the living kin, and can either be forces of healing or destruction depending on the circumstance in which they are exerting their influence (Dold & Cocks, 2012). Apart from the natural level of the universe, the amaBomvana also believed that there exists another level parallel to that of the living; that of the spiritual forces (Broster, 1981). The *izinyanya* (ancestors*)* are minor deities, and are forces for blessing or devastation, depending on the circumstance in which they are exerting their

influence (Broster, 1981). They punish social transgressions and those who overstep their freedoms (Dold & Cocks, 2012). The ancestors can greatly influence one's health as well as the health of whole families and communities because the knowledge and use of indigenous plants is believed to be received from the ancestral spiritual world (Mji, 2013). African belief in the ancestors is centered on the concept that life continues after death through the realm of the ancestral shades, and that relationships and communication channels are possible between the living kin and their departed kinfolks (Kamwaria & Katola, 2012). Fundamentally, the ancestoral shades are believed to be the spirits of deceased kin and thus act as intermediaries between the Creator and their living kin (Mbiti, 1969). They are believed to be spiritually involved in the practice of cultural religion and healthcare and can upon request send curative medicines to the living via the indigenous healers. Additionally, the ancestors are believed to have special dwelling places such as rivers, forests, oceans and mountains where they can be accessed and their medical knowledge obtained (Broster, 1981) (Mabona, 2004).

1.2.1.3 Indigenous understanding of health and wellness

For the amaBomvana good health requires not only a healthy physical body but also healthy spiritual relationships with the ancestors and with the environment (Mji, 2013). Ohajunwa (2018) describes the amaBomvana intricately by affirming that the amaBomvana "spiritual connections are sustained through various spiritual rites that are believed to facilitate connectedness to God and ancestors; self and others; the earth; plants; and animal life" (Ohajunwa & Mji, 2018, 7). These spiritual rites that Ohajunwa refers to include ritual sacrifice of goats, sheep, and cattle to appease the ancestors as well as the brewing of traditional beer known as *umqombothi* as a means of maintaining healthy relationships with the ancestral spirits through the assistance of animals, plants, vegetation and the environment of the amaBomvana (Mji, 2013) (Ohajunwa & Mji, 2018). The amaBomvana engage in certain processes that are primarily designed to protect their overall health through reinforcing their immmunity and that of their families to tolerate physical and spiritual injury. These processes involve the maintenance of a spiritual balance with their ancestors and natural environments through ceremony and religious expression (Winkel, 2010). To attain this balance numeral actions need to be implemented, such as communicating with the ancestoral shades through ritual sacrifice, consultation with indigenous healers and by the use of indigenous medicines known as *amayeza* (Foster, 1967). Communication with the ancestors for the maintenance of health is done by trained indigenous health practitioners (Dold & Cocks, 2012).

1.3 Evolution of the problem / Background

In South Africa, the topic of indigenous medicine remains a disputed field (King, 2012). Moshabela, Zuma & Gaebe (2016) maintain that tensions continue to dominate discussions around the role and practices of indigenous healers, particularly with issues pertaining to gaps in empirical evidence about the toxicity of indigenous medicinal products as well as the training procedures of indigenous doctors (Moshabela, et al., 2016). There is debate around how can we build and implement future health and national resource management for indigenous medicines whose pharmacological effects on the patient's body are not known or even corroborated with scientific evidence (Wreford, 2005). Resistance to the recognition of indigenous health practitioners has been due to the fact that without any ethno-botanical, biomedical or pharmacological scientific data for reference, there is currently no scientific basis for integrating the medicinal products and practices of indigenous medicine into the national health care system (Moshabela, et al., 2016). Furthermore, the *ukuthwasa* process by which indigenous health practitioners gain health knowledge and expertise has also been widely debated, mostly due to its highly spiritual nature rather than its focus on empirical evidence, with some arguing that *ukuthwasa* is a more of a process of intense spiritual awakening rather than of experiential medical training (Moshabela, et al., 2016). Despite the shortage of empirical evidence on the toxicity, pharmacokinetics and pharmacodynamics of some indigenous medicines, their use are still relatively common in South Africa, with persons and family units visiting with indigenous healers either to receive treatment or to collect medicines (King, 2012).

Globally, indigenous health practitioners tend to be more situated and practice in rural communities which are distanced from modern hospitals and clinics, meaning that they are often the first line of reference for health care for rural patients (Good, 1987). This is particularly true in areas such as Madwaleni with poor transport and a general lack of emergency services. In rural communities like these, the indigenous health strategies of indigenous healers are used to manage illness simply because indigenous healers offer culturally accepted methods of healing (Moshabela, et al., 2016). Mji argues that indigenous healers are preferred by indigenous patients because they are embedded in the community that the patient lives in and so are familiar with the patient's way of life, they share the same language background with the patient and also understands the patient's cultural beliefs (Mji, 2013). In Madwaleni, Mji found that some of the biomedical doctors in the hospital are not native Xhosa speakers and are unfamiliar with indigenous Bomvana cultural beliefs and therefore battle to connect with the patient and to understand the patient's descriptions of the illness they are experiencing during consultations. Xhosa speaking nurses are often asked to assist with the translation during consultations between doctor and patient (Mji, 2013).

Similar situations exist throughout South Africa, but also in many other rural communities around the world, making indigenous health knowledge (IHK) a developing area of study worldwide. In most recent years there has been a surge of studies focusing on the important role that indigenous medicine can contribute to global health. Stephens, Nettleton and Porter (2005) explored why the health status of indigenous peoples such as the Maori of New Zealand, the Aborigine of Australia, and the Bantu of Peru, is lower as compared to other population groups in those countries. The authors argue that the unwillingness by the Western medical field in these nations to accept the indigenous health system as valid health care system has proven to have detrimental effects on the health care status of the indigenous populations, resulting in overall low health status (Stephens, et al., 2005). The study findings "show that at best the health situation of indigenous peoples mirrors that of the world′s very poorest, but is made worse by their social and cultural marginalisation. Even in wealthier countries such as New Zealand and Australia, most indigenous peoples live in worse socioeconomic conditions than their non-indigenous counterparts" (Stephens, et al., 2005, 12). The study showed that when indigenous people are pushed to give up their indigenous health strategies, then their overall health status diminishes because most indigenous patients do not have adequate knowledge about Western healing methods to fully understand the particulars of Western medicine (Stephens, et al., 2005).

Mji (2013) also alluded to the same notion. Mji found that patients in Madwaleni who lived in close proximity to the hospital rarely wanted to discuss issues pertaining to indigenous health knowledge but were more knowledgeable about Western health strategies as compared to their more isolated counterparts, whereas patients who were much further removed from the hospital in remote parts of Madwaleni were less knowledgeable about Western health strategies and had a more comprehensive understanding of their own indigenous health knowledge (Mji, 2013). Both these authors suggest that indigenous health systems and their practitioners who are the holders of indigenous health knowledge be acknowledged as valid sources of health care within spaces of Western medical care so as to improve the health status of indigenous peoples (Mji, 2013) (Stephens, et al., 2005).

Also in Australia, research findings from a study by Durey and Thompson (2012) "support the view that a western biomedical model of practice delivered to indigenous patients, particularly from remote areas of Australia where English is not their first language, often leads to cross-cultural misunderstandings regarding disease causation and treatment that end up compromising health" (Durey & Thompson, 2012, 8). The authors argue that when indigenous patients are not given the opportunity to experience illness in both its cultural and religious understandings then that leads to a decline in the health status of those patients. Durey and Thompson (2012) have shown that the presence of indigenous healers plays a pivotal role in managing, treating and preventing the spread of disease in indigenous communities because they provide a socio-religious conceptual framework of

health that is culturally relevant for the patient, thereby allowing the patient to better understand their experience of illness (Durey & Thompson, 2012).

1.3.1 Problem statement:

Mji's work highlighted that many of the patients in Madwaleni that consult clinics and hospitals revealed that they are chastised by biomedical healthcare professionals for using indigenous herbs in conjunction with biomedical medicinal products (Mji, 2013). This reprimanding of patients by biomedical professionals stems from a lack of understanding on how indigenous herbs are prepared, utilized and administered to the patient (Mji, 2013). Skepticism about the efficacy of indigenous medicine is not unique to South Africa, in fact it is a phenomenon that is observed globally in counties that have an indigenous healthcare system existing alongside a Western health system, such as Australia, New Zealand, Peru, The United States and Canada to name a few (Stephens, et al., 2005). Scholars of indigenous health knowledge (IHK) argue that this prejudice is fueled by many factors, including colonialism, discrimination, and institutionalized racism against any health model that does not fit Western standards of health delivery (Durey & Thompson, 2012).

As Durey and Thompson point out, a big part of the problem that fuels the division between indigenous healers and biomedical professionals is lack of communication (Durey & Thompson, 2012). In Madwaleni, the general lack of communication between the indigenous healers and biomedical professionals in the clinics and hospital is an issue of concern (Mji, 2013). During a rural conference hosted by Mji in Madwaleni in July 2016, the indigenous healers of Madwaleni expressed that there is a great communication divide that exists between them and the biomedical professionals of the hospital and clinics, and that this division is affecting the healthcare of the patients. The healers claimed that this miscommunication creates a situation of confusion for the patients in the sense that on one hand they are discouraged from using indigenous health knowledge and to adopt a western healthcare model to treat disease, while on the other hand these same patients do not possess the western knowledge and training necessary to fully absorb the particulars of biomedical healthcare. The healers also revealed to Mji that their medicines are being rejected by biomedical professionals in the clinics and hospital. The healers expressed that their patients who seek to utilize both indigenous medicines in conjunction with biomedical medicines are discouraged from doing this by doctors and nurses. Hence, there is a need to first identify who the indigenous healers of Madwaleni are and to identify the exact illnesses these healers manage, and which herbs they use to treat each illness. Secondly, to present and catalogue the ethnobotanical diversity used by these healers, and to identify the precise botanical environment that these herbs grow as well as the relationship these healers have with these environments and lastly, to explore and present the relationship between indigenous healers of this area and their relationship with biomedical health care professionals. It is hoped that this

knowledge will help in the process of exploring how indigenous healers can work together with biomedical health professionals.

1.4 Motivation for the study

This study was built from the findings of Mji's (2013) PhD study that explored the health knowledge carried by older Xhosa women in their home situation, with special focus on indigenous knowledge. Mji observed that the older Xhosa women utilized indigenous knowledge (IK) and herbs from their land to assist in the management of health problems in their home situations (Mji, 2013). She further observed that these older Xhosa women would further consult other older Xhosa women outside the home when their relatives were not improving from the indigenous health knowledge (IHK) strategies they were using to try and help with their illness. Mji classified these older Xhosa women outside the home as "elite older Xhosa women" as they were renowned in their villages for their IHK.

Mji (2013) further highlighted the need for the biomedical professionals operating in Madwaleni to form partnerships with the indigenous healers of the area. There is an ongoing exploration of partnerships and relationships between biomedical professionals and indigenous healers in South Africa. Important work has already been done in the field of ethnopharmacology in and outside of South Africa that is aimed in bridging the knowledge gap in the literature in terms of studies that are aimed at documenting the indigenous practitioners as well as their herbs and plants. For many years researchers in South Africa have collaborated with indigenous healers and many projects are still being done in this field. Such studies include works by Victor, Smith & Van Wyk (2016), highlighting the robust history that has shaped the development of plant taxonomy in South Africa from about 1600 to 2015. These authors mention that with all the great discoveries that have been made in the field of ethnobotany in South Africa, it is estimated that about 5% (or 1100 species) of the current known flora is yet undiscovered (Victor, et al., 2016). However, unlike the Victor, Smith &Van Wyk (2016) study, this study is not concerned with the taxonomic classification of any plants in Madwaleni, but instead it aims to describe the indigenous plants that are used in Madwaleni to manage illness, along with their ancestral and spiritual significance with the hope that this information can be of use to the biomedical professionals that operate in the area who are unknowledgeable about the exact medicinal plants used by their indigenous patients or what these medicines symbolize for the indigenous population.

More importantly, Madwaleni poses as an interesting research area because it is situated in the intersection between biomedicine and indigenous medicine. The biomedical secondary hospital and the nine (9) clinics that are embedded in the villages of this area provides allopathic health care to various members of the community, with some approaches that might be considered foreign by the

less technologically advanced members of the community (Mji, 2013). This study hopes to show that the existence of these two groups need not be in opposition to one another. However, before the prospects of integration can be explored, reconciliation needs to occur. As stipulated by Mji's findings, the indigenous healing community in the area is ready to take steps towards reconciling the past and the present, with the goal of one day forming a partnership between the two systems (Mji, 2013). By conducting this research, the investigator wishes to provide the indigenous healers of Madwaleni with a platform to express their concerns, opinions and suggestions for how we can build coherence between biomedical doctors and indigenous healers in this reconciliation process.

1.4.1 The challenges caused by the entry of Western religion, formal education and biomedical healthcare in Madwaleni

The older elite women in Mji's study revealed that in their community, foreign Westernized education, religion and biomedicine have all had a negative impact on the health status of the indigenous amaBomvana people. Foreign entry was first introduced in Madwaleni as Western religion by the Dutch Reformed Church, which then expanded to Western formal healthcare, which further developed into Westernized education (Mji, 2013). These three Western-influenced institutionalized knowledge systems infiltrated indigenous amaBomvana communities who on their own community level had pre-existing knowledge systems and ways of understanding the world (Mji, 2013). Across many rural places in the Eastern Cape Province of South Africa where Western education was introduced by the Christian church, and unfortunately not everyone got to attend school nor go to church as the church initially required people to convert to Christianity in order to access school (Mtuze, 2004). In the case of Madwaleni, only those that had converted to Christianity attended formal schooling and subsequently visited the hospital for medical treatment (Mji, 2013). Because of this, a situation arose in which some members of the Madwaleni community were strictly holders of Western knowledge, while some were strictly holders of indigenous knowledge. The refusal by those who were holders of Western knowledge to accept indigenous knowledge as a valid school of thought brought a lot of discomfort to the indigenous amaBomvana because there was a lack of exchange of health and religious knowledge between the two groups, with the Western knowledge system claiming to be not just better equipped, but superior to the indigenous knowledge system (Mji, 2013). A local Chief of the amaBomvana even went as far as stating that Western religion, education and biomedicine had brought ill health to the amaBomvana solely in the manner in which they were introduced (Mji, 2013).

History shows that these were some of the ultimate effects of colonialism throughout Africa, that is, to distance the African person from his/her indigenous knowledge through the guise of Christianity and

formal education (Mbiti, 1969). Reverend Peter Mtuze, a scholar of African religion and philosophy, described the process by which Christianity and formal education imposed itself on African people as cruel in the sense that the Christian ideology termed African religious beliefs as pagan and demonic (Mtuze, 2004). The blatant refusal to acknowledge indigenous African religion as a valid religion has negatively affected African people throughout the continent. African philosopher John Mbiti defines African religion as belonging to the people (Mbiti, 1969). By this he means that religion for African people is a standard approach of observing the world and of experiencing life itself. For that reason, African religion is present wherever African people are because it is incorporated into all the various areas of African life. The power of religion covers one's complete life; from before birth to long after death (Mbiti, 1969). Scholar of African religion Beyers extends on this definition by stating that for African people, religion is "a human effort to systematise, in society, the continuation of religious experience relevant to a specific context. Tradition, expressed in rituals and ethics, becomes the social expression of these religious experiences" (Beyers, 2010, 4).

As revealed by Mji, the people of Madwaleni consider indigenous medicine to be an expression of their indigenous religious beliefs (Mji, 2013). Although African indigenous religion does not discourage using a Western medical approach to manage illness, its supporters believe that there are some illnesses that Western medicine cannot treat, such as those pertaining to witchcraft, spirituality and ancestral connection (Good, 1987). In spite of the introduction of Western medicine and healthcare systems in Africa, many African communities still rely on indigenous medicine for diagnosis, prognosis and treatment, even in cases of severe illness such as HIV and AIDS (Wreford, 2005). As White (2015) observed in her study of the indigenous people of Ghana, in the indigenous understanding of illness, evil spells and witchcraft are also other ways one could become sick (White, 2015). Therefore as the White (2015) study shows, many indigenous people believe that certain illnesses which defy Western science can be transmitted through witchcraft, such as barrenness, infertility, loss of marriage and joblessness (White, 2015). However, some IKS scholars such as King (2012) and Kamwaria & Katola (2012) argue that the introduction of Western religion, education and healthcare has challenged the validity of the indigenous African philosophy towards understanding and managing illness (King, 2012) (Kamwaria & Katola, 2012). For example, Western medicine does not generally describe witchcraft as a diagnosis for infertility, and very few medical doctors will accept joblessness as an illness (Kamwaria & Katola, 2012). This creates a situation where the indigenous patient feels guilty and ashamed for understanding their illness using the indigenous perspective (King, 2012). A more nuanced exploration of this phenomenon is explored in the literature review chapter.

1.4.2 Critical research questions

Based on the findings of Mji (2013), critical research questions emerged as motivation for this study. These questions include:

- Who are the indigenous healers of Madwaleni and what illnesses do they manage?
- What medicines are used by the healers to treat these illnesses?
- How is medicine prepared and where do these medicines grow?
- What is the relationship between biomedicine and indigenous medicine in Madwaleni?

1.5 Aims and objectives

Firstly this study aims to explore and identify the types of indigenous healers found in Madwaleni, to identify the types of illnesses they manage, as well as to identify the medicinal plants the healers use. Also, an exploration of the relationship between ethnobotany and healthcare was to be undertaken. Secondly the study aim was to explore the relationship between the indigenous healers and the biomedical health professionals in the study area.

1.5.1 Objectives

The study objectives are to:

- Identify the types of indigenous healers of this area.
- Identify the illnesses these healers manage.
- Describe and catalogue the herbs (ethnobotanical diversity) used by these healers to treat each illness.
- Identify and describe the precise botanical environment that these herbs grow.
- Describe the relationship these healers have with these environments.
- Describe how the indigenous healers of Madwaleni and health professionals could work together including the process and steps to be taken to improve the relationship.

1.5.2 Theoretical and conceptual underpins of the study objectives

Scholars of IKS have attempted to provide theoretical frameworks for the study of the relationship between medicine and culture. Kleinman encourages that the study of IKS and biomedicine should rather take an ethnomedical approach that looks at “a health care system as a cultural system of symbolic meanings anchored in particular arrangements of social institutions and patterns of

interpersonal interactions" (Kleinman 1980: 28). Kleinman suggests that in order for us to truly appreciate the similarities and differences between the biomedical system and the indigenous health system, one has to understand the three core themes of health, which are entrenched around the health-related components of society (Kleinman, 1980).

In his health model, Kleinman suggests that the primary model of treating illness falls within what he terms as the "popular sector", whereby illness is treated within the home by non-professionals in the absence of folk healers or medical professionals (Kleinman, 1980). In this sector, the family unit is the primary health care resource. However, should the illness persist and the family deems it difficult to treat within the family unit, outside help is sought after in the form of indigenous healers or biomedical professionals, or a combination of both.

The second sector mentioned in this health model, where illness is managed outside of the family unit by trained indigenous healers in the form of folk healers, medicine men/women and priests, which Kleinman terms as the "folk sector". The third and final sector described in this model is the "professional sector" comprised of Western medically trained professionals such as doctors, surgeons or nurses (Kleinman, 1980). He places a hierarchy between these three sectors, with the "professional sector" being the most complex of them all because Kleinman believes biomedical healing methods are much more complex and technologically advanced than folk strategies. The image below depicts Kleinman's health care model in the context of culture. The image is extracted from the study authored by Fenega, C, Alhassan, R, Duku, S, et al 2016. Disparities between Explanatory Models of Health Clients, Healthcare Providers and Health Insurer. *Journal of Health Sciences,* **4**(2016), pp. 1-14.

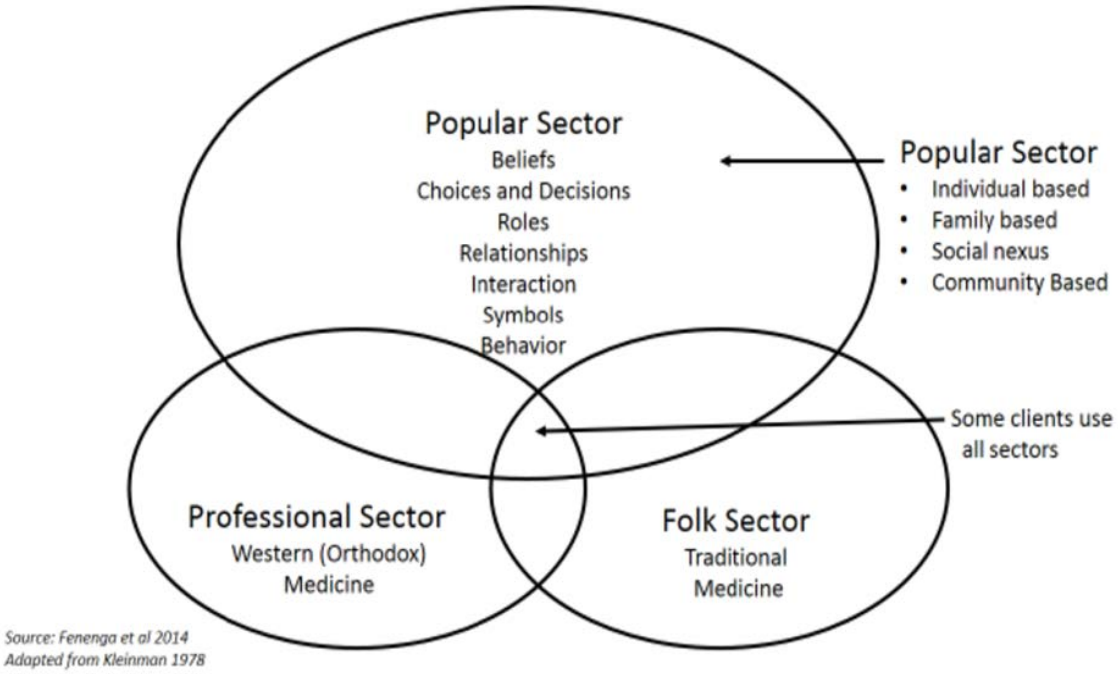


Figure 2: The Kleinman health care model showcasing the three sectors of health management and critical points of intersection.

Kleinman believes that the inner structures of health care systems are similar across cultures, but the difference lies in the context, which is shaped by social, environmental and cultural situations (Kleinman, 1980) (Fenenga, et al., 2016). As described in his model, the popular sector is occupied by non-specialist, non-professional lay healers who manage illness within the home situation. Although Kleinman suggests that self-treatment is a major factor in this sector, many other scholars such as Mji argue that actually the whole family unit and not just the individual, often serves as the primary health care provider in this sector (Kleinman, 1980) (Mji, 2013). In relation to the situation in Madwaleni, Mji suggested that the first point of entry for the management of illness is primarily occupied by older Xhosa women. Mji proposed that the older Xhosa women only moved into the folk sector space by referring their sick to other healers when the strategies they were utilizing were not working. Kleinman describes this folk sector as a space that includes both sacred and secular folk healers, including but not limited to shamans and herbalists. One important function of the folk sector as described by Kleinman is that it denotes the cultural construction of illness as a psycho-social experience (Kleinman, 1980). Hence, he stipulates that the understanding of illness in the folk sector is wider and more holistic than in the professional sector.

According to Kleinman, in the professional sector which comprises of medical professionals and organised healing occupations, illness is more defined by mechanistic, material definitions and is limited by its ethnocentrism and scientism (Kleinman, 1980). In South Africa, it is estimated that approximately around 80 % of people manage illness outside of the biomedical health system, with

many people moving between the folk and professional arenas, although that number still remains contested (Mokgobi, 2014). In many communities across South Africa that boast extensive biomedical healthcare provisions, people still prefer to integrate the indigenous medical system with the biomedical system in order to manage disease (Moshabela, et al., 2016). Kleinman states that in communities that have both indigenous and biomedical systems present, people will still choose to use these systems interchangeably. He suggests that the reason being that the shaping of disease into behaviour and experience is what drives people to step out of the organized professional sector and into the folk sector (Kleinman, 1980). Kleinman does however caution that "health care systems are nearly impossible to understand once they are removed from their cultural contexts. All the greater reason for seeking to discover as much as possible the cultural beliefs, values and behaviours that govern health and illness within a particular culture" (Pilch 1995, 322). However, it is critical to note that Kleinman's health model fails to take into account the fact that in some cases, such as Madwaleni, the folk arena and the popular arena do intersect interchangeably and the lines of delineation are not always so clear and succinct. As Mji (2013) discovered, the healers within the popular arena share patients with the healers in the folk arena, making the borderlines between these two arenas a grey area. This then requires us to take a critical analysis into the framework of Kleinman's model and its application in Madwaleni.

1.5.3 Critical analysis of Kleinman's framework

As much as Kleinman describes the functions of the folk sector, there is a need to critically analyse his concepts. Kleinman's theory suggests that the three sectors exist in isolation from one another and can be categorized in neatly designated categories (Pilch, 1995). This is not entirely convincing that this is always the case. In the rural community of Madwaleni, the arenas are no as neatly designated as suggested by Kleinman's model because of the nature of the community, cultural values and history. As Mji revealed, the amaBomvana experience illness in both its personal and communal aspects, meaning that when one person is sick, the burden of managing the person's health is not just carried by the patient, but it is rather shared amongst the members of the patient's family unit and amongst the rest of the community in which the patient lives (Mji, 2013). So during times of illness, the patient is treated within the family, but with the assistance of other health care professionals within the community that fit the cultural context, such as indigenous healers, who may also be part of the family unit. If the illness progresses and cannot be managed within the family and community, 'outside' help is sought after in the form of biomedicine. This means that the primary, folk and professional sectors are in constant motion with one another in Madwaleni and boundary lines are not as clear and overt as the Kleinman model suggests.

The Kleinman health model is significant because it highlights the very important concept that illness is a cultural construct that is experienced in both its personal and social realities. Conrad & Barker (2010) argue that "the social construction of illness has become a major research area in the subfield of medical sociology, and it has made significant contributions to our understanding of the social dimensions of illness" (Conrad & Barker 2010: 67). This stipulates that illness can be anything that the culture perceives and values as an illness, even if it may not have any physical or pathological basis for concern. However, Kleinman distinguishes physical disease as a health concern that falls into the arena of biomedicine, it appears that Kleinman believes disease to not be a spiritual reality but rather "an explanatory concept that describes abnormalities in the structure and/or function of the human organs, including pathological states that are otherwise not recognized culturally" (Pilch 1995: 320). For that reason, the suitability of Kleinman's theory when studying a population like the amaBomvana that largely believes illness to be both a physical and a religious reality is challengeable.

In his work, Pilch (1995) closely examines the Kleinman health model and how it translates to the methodological approach for studying indigenous health systems. Pilch argues that using a cross-cultural approach to study health systems "allows the investigator to interpret texts and events from other cultures with respect for their distinctive cultural contexts in order to draw more appropriate conclusions and applications" (Pilch 1995: 314). Pilch stipulates that because the whole indigenous health system is designed to bring about healing, the investigator studying an indigenous health system "needs to conduct both a micro and a macro analysis to see how small-scale events within the healing system might relate to large-scale social structure and processes" (Pilch 1995: 318).
In his analysis of Kleinman's theory, Pilch (1995), lists three ways to investigate illness and healing across cultures:

1. Use concepts that were intended to study other areas of human health and use them to describe the health-care beliefs and practices of the study population. That is, anthropological concepts can be used to investigate the effects of witchcraft, magic and superstition on the body as is observed in that culture.
2. Use concepts from medical sociology to understand the interwoven link between natural environment, human biological and socio cultural understandings of health as is observed in that culture.
3. Develop an evolving conceptual definition of health and illness based on the social and practical understandings of illness and health as it is observed in that culture (Pilch, 1995).

Pilch argues that these three ways will work only if in that particular culture religion and health exist as separate entities in the way that they do in Western cultures, but will not work in cultures where religion and health are merged (Pilch, 1995). Therefore, in societies like Madwaleni where religion and health cannot be separated, Kleinman's model is not enough to study the local indigenous health

system in depth. Pilch proposes that Kleinman's theory needs to be supplemented with knowing a culture's paramount sources of power, whether political, social, religious, or technological, as these will allow the investigator to deduce the beliefs about the causes of illness and how to effectively treat it (Pilch, 1995). Meaning that each illness must be analysed according to which lens of power it is being experienced as this will greatly determine which health strategy within the health system will be used in the management of that illness. According to Pilch, social reality determines what that power is. In some cases the power might be witchcraft, exorcism, fortune-telling, surgery or psychotherapy (Pilch, 1995). In any case, these various sources of power lay down the pathways for which health care strategy will be most effective. In tum, political, socio-economic, and cultural powers determine which view prevails and which outcomes are acceptable (Pilch, 1995). Hence, the main deductions from Pilch's analysis is that when illness is linked to social reality and the application of power, it becomes difficult to describe an entire health system in three categories as Kleinman claims. This study argues that surely the descriptions and categories of sectors described in the Kleinman model should be much broader when all the political, socio-economic and cultural dynamics of power have been accounted for.

1.5.4 Study boundary:

As already mentioned, this Master's study emerged from the findings of Mji's PhD study that was exploring the health problems managed by older Xhosa women in their home situations. Mji's study further identified that when these women were struggling with managing the illness within the home, they would consult with other older Xhosa women. Mji, classified these other women as the "elite older Xhosa women". Both the older Xhosa women and elite older Xhosa women seem to occupy the popular arena space in Kleinman's health model.

Hence this study is primarily focused on exploring the healers that reside in the folk arena as identified by the older Xhosa women in Mji's study. The terminology used to describe these group of healers for this thesis differs from that of Mji's study. For this thesis, these set of healers are classified as "the indigenous healers of Madwaleni". The study further explores the relationship between these groups of healers that operate in the folk arena with the biomedical healers that operate in the professional arena.

1.6 Relevance of the study

Mji in her study proposed that there is still a need to document the names of the practitioners of indigenous knowledge in the Madwaleni area as well as the plants that they use to treat disease within their community (Mji, 2013). Mji's findings show the disjuncture within biomedicine in Madwaleni

where biomedical professionals reprimand indigenous healers for utilizing their knowledge to manage the health of patients that are using biomedical medicines (Mji, 2013). Mji claims that this reprimanding is what has resulted in the indigenous healers of Madwaleni not wanting to share their IHK with biomedical professionals (Mji, 2013). She maintains that the veil of secrecy around IHK can be lifted when biomedical professionals show regard to indigenous healers. This study aims to aid in that process of lifting the veil of secrecy by conducting a thorough investigation of the indigenous healers of Madwaleni and their practices. It is envisioned that the lifting of this veil of secrecy would possibly assist to uncover more concrete plans on how biomedicine and indigenous medicine can cooperate in Madwaleni.

Other IKS scholars in South Africa agree that the importance of indigenous medicine in global health care is increasingly recognized as shown by the increased academic interests and debates surrounding the practices of indigenous healers and the ethnobotanical products they administer to their patients (Moshabela, et al., 2016), however, some IKS scholars argue that this alone is not enough because there is still a shortage of ethnographic pharmacological studies that explore the use of indigenous medicines within the exact indigenous knowledge systems in which those medicines are utilized (Etkin & Elisabetsky, 2005). Indeed indigenous healers are increasingly acknowledged as essential providers of health care throughout the world, and in South Africa the National Department of Health has taken some steps towards the formal recognition of indigenous medicine as an authentic health discipline (Moshabela, et al., 2016). However, there is a lot that still needs to be done before indigenous healers can be recognized and respected as valid healthcare professionals within biomedicine in isolated regions of the country such as Madwaleni. This study hopes that by documenting and describing the indigenous healers of the Madwaleni region and the unique ways in which they relate to their ethnobotanical environment to treat illness in their community would possibly assist in bridging the knowledge gap between biomedicine and indigenous medicine in Madwaleni.

1.7 Presentation of this study

This thesis will be presented in the form of 6 individual chapters; Introduction, Literature Review, Methodology, Presentation of Findings, Discussion of Findings, Conclusions and Recommendations. Included after the 6th chapter is an Appendix section that comprises, acceptance of the study by Ethics and Human Research Committee of Stellenbosch University, consent forms, interviewing guide, a list of illnesses managed by the older elite Xhosa women in Mji (2013) study and 4 individual draft articles emerging from the findings of this study.

1.8 Summary of the Chapter

This chapter provided a detailed background of the study, it's objectives as well as the theoretical underpins of these objectives. It provided the reader with a detailed description of the study setting and the belief systems of the study population. A broader and more critical analysis of literature that has been published in the field of indigenous health systems is offered in the following chapter.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter serves as literature review of this thesis. The purpose is to provide the reader with a factual background of the topic of indigenous health by offering a review of some of the literature that has already been published in the field. Firstly, a critical evaluation of published research is done, showcasing what has worked and hasn't worked for researchers doing work in the various fields of ethnopharmacology around the world. Each literary work is placed within the context of its contribution to the research problem of this study. The broad topic of indigenous health is explored across various global indigenous cultures as well as in South Africa. Secondly, this review chapter also serves to highlight any gaps that exist in published literature and how these gaps can be filled. The chapter also explores the role of amaBomvana understandings of health since this indigenous population is the key focus of this Master's thesis.

For this chapter, a reflective survey of books, scholarly articles and other relevant sources that address the area of research was conducted with the purpose of developing a solid critical evaluation of the research problem being investigated.

2.2 The challenge of defining indigenous health

The issue of defining a standard definition of health and what effective health care is has proven to be a challenge globally because determinants of health vary from country to country, and can be affected by factors such as economic status, poverty, gender, race and age (Gracey & King, 2006). This means that the conditions into which people are born, grow, live, work and also their age affects their health status because these conditions are shaped by the distribution of resources and power at global, national and local levels within and between countries (WHO, 2018). The World Health Organization (WHO) estimates that women and children still remain among the most vulnerable populations in many countries around the world, further supporting the idea that social determinants of health can greatly affect health status (WHO, 2018). Based on the acknowledgement that there are many factors that determine one's health, the WHO now defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2018). For many indigenous people around the world, this WHO definition is more fitting because most indigenous populations believe that health is attained when the complete balance between mind, body and soul is

achieved through the maintenance of solid relationships between all members of society, the ancestors and the natural environment (Mji, 2013).

2.3 Who are indigenous people?

As it currently stands, the WHO does not have an official definition for the term 'indigenous', but has developed an understanding of 'indigenous people' as people who:

- "Identify themselves and are recognized and accepted by their community as indigenous."
- "Demonstrate historical continuity with pre-colonial and/or pre-settler societies."
- "Have strong links to territories and surrounding natural resources."
- "Have distinct social, economic or political systems."
- "Maintain distinct languages, cultures and beliefs."
- "Form non-dominant groups of society."
- "Resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities" (WHO, 2007).

This definition also stretches to include people who are described using other terms such as 'tribes', 'first peoples', 'aboriginals', or 'ethnic group' as the use of these terms varies from county to country (WHO, 2007).

2.4 What is indigenous health?

Various indigenous groups around the world carry their own understandings of health and according to Article 24 of the United Nations Declaration on the Rights of Indigenous Peoples (2008), "indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services" (UN 2008: 9). Essentially, this means that indigenous people have a right to practice health within the context and understandings of their cultures.

In this section of the literature review, an exploration of the indigenous health models of the indigenous peoples of Australia, New Zealand, United States and Canada, as well as South Africa will be explored with the aim of developing an understanding of the definition of health according to various indigenous peoples around the world.

2.4.1 Aboriginal health in Australia and New Zealand

In Australia, the Aboriginal definition of health refers "not just to the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their community" (Durey & Thompson 2012: 9). This worldview also "includes the cyclical concept of life-death-life" (NACCHO, 2006). In Australia the word 'Aboriginal' is used instead of 'Indigenous' as "the term *Aboriginal* is inclusive of all Aboriginal and Torres Strait Islander Peoples" (New Zealand, 2013). However, in academic studies, New Zealand uses the terms indigenous and Aboriginal interchangeably (New Zealand, 2013). According to the New Zealand Ministry of Health, the most prominent indigenous group in the country are the Maori people. The indigenous "Maori philosophy towards health is based on a wellness or holistic health model" (Health, 2015). The Health Ministry's official government website provides a detailed explanation of the indigenous Maori health system, which can be summarised as follows below.

The Maori indigenous health understanding is based on three key models; *Te Whare Tapa Wa, Te Wheke and Te Pae Mahutonga* (Health, 2015). The *Te Whare Tapa* model consists of four (4) embedded concepts;

1. *Taha tinana* (physical health)

This concept denotes that physical health is required for optimal physical growth and development.

2. *Taha wairua* (spiritual health)

This concept denotes that "the spiritual essence of a person is their life force. This determines us as individuals and as a collective, who and what we are, where we have come from and where we are going" (Health, 2015). An individual's spiritual health is related to spiritual energies.

3. *Taha whānau* (family health)

This concept denotes that individuals are part of a wider social system that includes family, ancestors, community ties to the past and the future as well as the environment.

4. *Taha hinengaro* (mental health)

This concept denotes that "an individual's thoughts, feelings and emotions are integral components of the body and soul" (Health, 2015). Essentially this concept represents the understanding that mind and body are inseparable.

The second Maori health model as described by the New Zealand Health Ministry is the *Te Weke* model. In this model, "health acknowledges the link between the mind, the spirit, the human connection with family, and the physical world in a way that is continuous and natural" (Health, 2015). Essentially this model revolves around family heath as key determinant of an individual's health status. In this model there are ten (10) concepts whose purpose is to clearly define what constitutes family health. This includes:

1. *Te whānau* – the immediate family including parents and children of the household
2. *Waiora* – total wellbeing for the individual and family unit
3. *Wairuatanga* – spirituality practised within the family unit
4. *Hinengaro* – the collective mind or consciousness of the family
5. *Taha tinana* – physical wellbeing of all members of the family unit
6. *Whanaungatanga* – other extended family members such as uncles, aunts, grandparents, etc.
7. *Mauri* – life force in people and objects within the family unit
8. *Mana ake* – unique identity of individuals and family such as family/clan names
9. *Hā a koro ma, a kui ma* – breath of life from the ancestors of the family
10. *Whatumanawa* – the open and healthy expression of emotion within the family unit

The third Maori health model described by the Ministry is *Te Pae Mahutonga* model. This model represents the four (4) key tasks of health promotion that each member of the community is expected to uphold within an indigenous community setting (Health, 2015). These tasks include:

1. *Mauriora* – maintaining and promoting a unified cultural identity of the community
2. *Waiora* – maintaining a healthy physical environment that exists naturally within the community
3. *Toiora* – the promotion and maintenance of healthy lifestyles within the community
4. *Te Oranga* – healthy participation in society and in community events

Despite this richness in culture and understanding, the indigenous health system of the Maori remains absent from the national health care system in New Zealand due to a lack of representation and acknowledgement of indigenous Maori health concepts in the mainstream biomedical health care system of the country (Health, 2015).

2.4.2 Indigenous health in the United States and Canada

The indigenous people of North America live in the United States and Canada (IWGIA, 2017). Indigenous people in Canada are referred to as 'Aboriginal' Canadians, where the term 'Aboriginal people' jointly refers to the first inhabitants of Canada, including the First Nations, Inuit, and Metis peoples (Health, 2011). According to Statistics Canada, there are over a million people in Canada who identify as Aboriginal, representing 4.3% of Canada's total population (Canada, 2015). In the United States, indigenous peoples are mainly American Indian peoples and Alaska Native peoples (IHS, 2018). In May 2016, 567 indigenous tribal entities were federally recognised in the Unites States, and most of these have recognised national homelands known as Native Nations which are sovereign but remain wards of the state (IWGIA, 2017).

Anthropologist Dapice affirms that the indigenous health models of North America are based on an understanding of "the healing relationship as being based on a series of virtues such as respect; humility; compassion; honesty; truth, sharing, hospitality and divine love" (Dapice 2006: 251). These virtues form the foundation of indigenous care amongst the indigenous North American peoples (Dapice, 2006). There are many routes to healing, but three main routes are commonly mentioned in literature including meditation, physical movement and healthy diet (Dapice, 2006). These routes are represented in what is called a Medicine Wheel (Dapice, 2006) (Ottawa, 2017). According to the University of Ottawa, "the medicine wheel symbolizes the interconnection of all life, the various cycles of nature, and how life represents a circular journey" (Ottawa, 2017). The medicine wheel is designed to have four (4) realms/spheres of healing symbolising the 4 aspects of health that should always remain in balance; spiritual, mental, physical and emotional. As stated by the University of Ottawa, "the number four is sacred to the many indigenous peoples of North America and can represent many things: the four seasons, the four parts of a person (physical, mental, emotional and spiritual); the four kingdoms (animal, mineral, plant and human); the four sacred medicines (sweetgrass, tobacco, cedar and sage)" (Ottawa, 2017). Hence, the medicine wheel can be presented in several different ways. Image is extracted from the official academic website of the University of Ottawa, Canada.

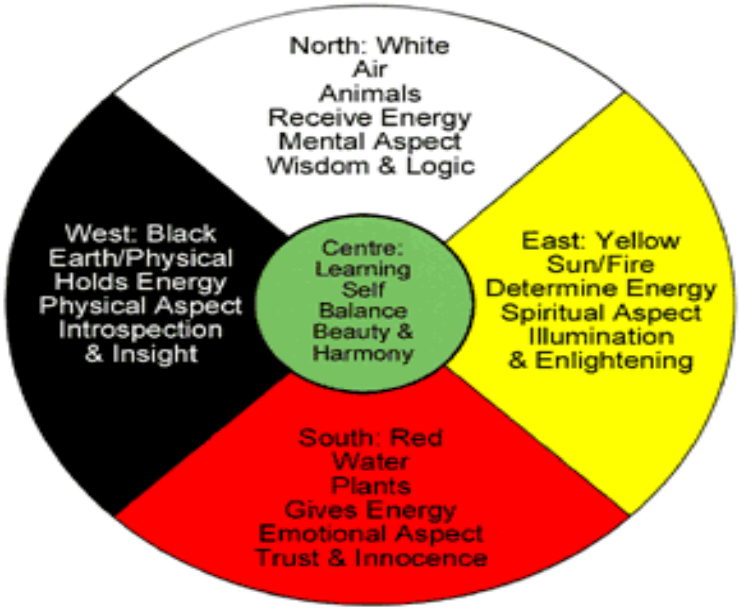


Figure 3: The Medicine Wheel of the indigenous peoples of North America.

According to Dapice (2006), the medicine wheel stretches to include all the four directions (North, South, East, West) and all the four aspects of health (mental, emotional, physical, spiritual) and all these spheres overlap with one another in various stages in a person's life (Dapice, 2006). The "four points of the wheel, each with a guiding spirit, symbolize stages in the life journey" (Ottawa, 2017). The University of Ottawa describes the wheel in terms of its relation to the compass. The "East, direction of the daily birth of the sun, represents a person's birth and early years. The South relates to childhood and intellectual growth. The West symbolizes adulthood and introspection, while the North represents the old age, wisdom and the spiritual aspects of life. The centre of the wheel is symbolic of Mother Earth and the Creator, and their role in the beginning and continuation of life" (Ottawa, 2017).

The medicine wheel also showcases the 4 healing plants that have symbolic significance to the indigenous peoples of North America (Dapice, 2006). Sweetgrass is used for ritual cleansing and spiritually it is associated with strong virtue (Rausch & Schlepp, 1994) (Dapice, 2006). Tobacco is used to connect with the spirit world as it is believed to absorb prayer and to transmit the messages in prayer to the ancestors residing in the spirit world. Cedar is used for purification and to attract positive energy and emotions that sustain emotional balance. Sage is also used for purification that drives away negative energies that lead to illness. Sage is used to bring strength, wisdom and clarity that all contribute to overall spiritual health (Rausch & Schlepp, 1994) (Dapice, 2006). This indigenous understanding of health and medicine has influenced many alternative health strategies of healing across the field of modern medicine in North America (Ottawa, 2017).

2.4.3 Indigenous health in South Africa

Ohenjo, Willis, Jackson & Mugarura (2006) concur that "Africa's 906 million people have been the focus of intense international attention since 2005 especially in relation to achieving the Millennium Development Goals, averting health service collapse, and attacking the disease burden" (Ohenjo, et al., 2006: 1937). However, the authors do argue that "of this 906 million people, the indigenous peoples of the continent have received little attention, although the African Commission on Human and Peoples' Rights (ACHPR) in 2005 described them as some of the most vulnerable groups on the African continent whose health situation is often very precarious and receives very limited attention from the responsible modern health authorities" (Ohenjo, et al., 2006: 1937).

Edwards argues that in the case of South Africa, indigenous "medicine is most commonly practised in rural areas lacking in modern health care facilities and hence the distinction between 'modern' and 'indigenous' medicine is absolutely arbitrary when one considers the personal, interpersonal and community variables affecting the interchange between healers and patients within the total healing context" (Edwards 1986: 1273). He argues that although modem "medicine is increasingly accepted as the treatment of choice by most" South Africans, in rural parts of the country "eclectically chosen combinations of modern and indigenous medicine remain common" (Edwards 1986: 1273). This trend, as he argues is commonly observed not just in South Africa but across the continent of Africa, because of the "relative differential emphasis of the two systems on content and cause or the 'what and why' of illness and health respectively" (Edwards 1986: 1273). In South Africa, as in other African countries, the issue of integration/cooperation between indigenous and Western medicine is a continuing one and it is not easy to navigate (Green & Makhubu, 1984).

The South African indigenous health system has been studied extensively in the country and many publications have described the various types of indigenous healers found across the various cultures of South Africa. A 1931 study by Cook documented the indigenous medical system of the amaXhosa people of the Eastern Cape and highlighted the various religious beliefs that have shaped the medical system of the amaXhosa (Cook, 1931). Work by Broster in 1981 improved on the findings of Cook by focusing on the exact medical professionals that operate within the Xhosa medical system (Broster, 1981). Years later, pharmacologists Bhat & Jacobs explored the medicinal plant products used by the amaXhosa and provides an analysis of the safety, toxicity and regulation of these medicines (Bhat & Jacobs, 1995). Edwards cautions that 'while on the surface there may be great variation in indigenous practices in South Africa due to its immense cultural diversity, core universal components exist which are shared by many indigenous peoples across the world, such as supernatural magical and religious practices, traditional diviners and herbalists" (Edwards 1986: 1274). Edwards further cautions that although the archetypal role of the indigenous healer is common across global indigenous cultures,

"broad non-mutually exclusive categories of indigenous healers should be avoided" (Edwards 1986: 1273). This is particularly true because each culture practices medicine in its own cultural, historical and social understandings.

Earlier South African literature describes mainly three types of South African indigenous healers; the indigenous doctor (sangoma), the herbalist (inyangi) and the Christian faith healer (umthandazeli) (Berglund, 1989) (Bhat & Jacobs, 1995) (Broster, 1981) (Cook, 1931). Although, more current works by IKS scholars such as Dolds & Cocks, Gqaleni, Mji and Setswe have extended this number by including traditional birth attendants (ababelekisi), traditional surgeons (iingcibi), traditional nurses (amakhankatha) and elite older women as part of the types of indigenous healers that operate in South Africa (Dold & Cocks, 2002) (Gqaleni, 2006) (Mji, 2013) (Setswe, 1999) . Setswe claims that there are approximately 200 000 indigenous healers operating in South Africa, although the number is a rough estimate due to the fact that there is currently no data base in place that keeps record of trained indigenous healers in the country (Setswe, 1999). Various researchers outline the types of indigenous healers and their approach to healing. The outline can be summarised as follows:

- **Indigenous doctor (sangoma)**

The *sangoma* is sometimes referred to as the diviner in some literature citations (Dold & Cocks, 2012) (King, 2012). Essentially the role of the indigenous doctor is to divine the circumstances of an illness in the cultural context (Setswe, 1999). The *sangoma* can be either male or female, and his/her speciality is spiritual divination, known as *ukuvumisa*, where the ancestral spirits are evoked to offer insight into the causes of illness and the action that can be taken to restore health (Broster, 1981). Essentially, *sangomas* operate within an indigenous religious supernatural context and act as medium to the real of the ancestors (Foster, 1967). Vocation to become a *sangoma* is not by choice, rather one is called to the practice by the ancestors of his/her family clan (Gqaleni, 2006) (Mabona, 2004). The person then undergoes rigid training regimen referred to as *ukuthwasa*, under the apprenticeship of a trained *sangoma* for several months or years (Gqaleni, 2006). Phonetically, the term 'sangoma' is a Zulu word but is used across the various cultures of South Africa (Kropf, 1915). The amaXhosa people of the Eastern Cape Province refer to *sangomas* as the *amaGqirha* (Broster, 1981) (Dold & Cocks, 2012).

- **Herbalist (inyangi)**

The *inyangi* are healers who specialize in the preparation, administration and use of plant or animal based medicinal preparations for treating illness (Setswe, 1999). Their wide-ranging knowledge includes knowledge about curative herbs, natural treatment of both plant and animal origin, as well as

preventative and prophylactic preparations for luck and good fortune (Mabona, 2004) (Setswe, 1999). Again, although the practices and roles are similar, there are some differences in language used to denote the herbalist healers. The term *inyangi* is of Zulu origin (Berglund, 1989). The amaXhosa people refer to the *inyangi* as the *amaXhwele* (Broster, 1981).

- **Faith healer (umthandazeli)**

The majority of black South African practice a combination of Christian and African religious beliefs (King, 2012). The *umthandazeli* are usually professed Christians who belong to either mission or African independent churches (Setswe, 1999). They heal using Christian relics such as holy water, rosaries, prayer and by laying hands on the patient (Setswe, 1999). The key difference between the faith healers and other South African indigenous healers is that among the faith healers the gift of healing is believed to come from God and not the ancestral spirits (Mabona, 2004).

2.4.3.1 The South African indigenous approach to healing and medicine

The concept of medicine in South Africa has long existed before the development and spread of modern medicine (Setswe, 1999). The realm of South African indigenous medicine is a realm in which there is no theoretical separation of the natural and supernatural worlds (Beyers, 2010). The theory underlying the cause of illness amongst black South African is fairly similar. The belief is that illness is a supernatural phenomenon governed by the broken relationships between living persons, the ancestral spirits, animals, plants and other objects found in the environment (Mji, 2013). Health therefore is a state of complete harmony between all these entities (Ohenjo, et al., 2006).

The South African indigenous healing process follows different key stages to bringing about health (Mokgobi, 2014). Firstly there has to be an identification of the illness and its causes (Mokgobi, 2014) (Setswe, 1999). This is done through the process of divination during consultation with an indigenous doctor. The second step is the neutralization of the cause of illness either by the removal of source of illness through the use of medicinal plants and herbs, or through ritual sacrifice to appease the patient's clan ancestors that are believed to govern the patient's health (Mokgobi, 2014) (Setswe, 1999). In all the various stages of healing, the patient is healed within context of family and community (Mji, 2013). The burden of illness is shared amongst fellow community members and all members partake in the healing process by showing support and Ubuntu to the patient (Mbiti, 1969) (Mji, 2013).

2.4.3.2 Nature and biodiversity as determinants of health

The link between human health and the natural environment is a robust and active field in academic research, with many scholars agreeing that health and well-being are significantly affected by environmental conditions (Sandifer & Sutton-Grier, 2014) . There exists a great and emergent body of literature that validates that interaction with the natural environment can result in measurable psychological and physiological health benefits as well as other several constructive properties (Sandifer, et al., 2015). Indigenous African peoples essentially believe that illness can be caused by sources within the body or sources from outside the body (Good, 1987). Basically, there is an understanding that the environment within one's body is as equally important as the environment outside of one's body in terms of maintaining good health. The African indigenous health system places a great amount of emphasis on eating well, using natural medicinal products, strengthening relations between the self, the family and the ancestors through ritual and ceremony, and through practising altruism commonly known as *Ubuntu* (Mji, 2013) (Mbiti, 1969). Of course, despite this, it is still understood that the causes of illness are varied, but fundamentally the core belief is that an individual's health is determined by the living environment, diet, relationships and life-style (Henriques, 2013).

Henry Callaway, an Anglican minister who worked with indigenous Zulu people in the 19th century, in his publication *Tales, traditions and histories of the Zulus (1866-68)* recounts the indigenous Zulu story of creation. In this story, God the Creator sent a chameleon to take a message to the humans which says that all human beings must die. However, the chameleon was very slow and kept stopping to eat fruits from the trees he came across. So God decided to send a lizard instead to tell the humans that they actually will not die after all. Because the lizard was diligent, he arrived first before the chameleon and was able to deliver the message. The chameleon arrived second. This left the humans confused and not knowing which message was true and which was false. This inspired the humans to dedicate their lives to doing good so that if they did die then God will accept them into the afterlife and they can be reunited with their ancestors (Callaway, 1868). The significance of this story is that it indicates the reliance of the indigenous Zulu people to nature, not only in the form of plants, but also in animals. This story demonstrates the important role that the natural environment plays in indigenous spirituality, as well as accentuating human fragility and vulnerability.

2.4.3.3 The economic significance of indigenous medicine in South Africa

One of the other ways in which indigenous medicine contributes positively in the lives of indigenous people in South Africa is through strengthening the household economy. According to Mander, Ntuli & Diederichs (2007), the trade of indigenous "medicines in South Africa alone is estimated to be

worth R2.9 billion per year, representing 5.6% of the National Health Budget" (Mander, et al., 2007). The authors state that the indigenous medicine market has played an important role in improving the household economy in many black communities in South Africa, both rural and urban (Mander, et al., 2007). A study by Bhat and Jacobs (1995) charted the economic use of indigenous medicine in the Eastern Cape and found that various indigenous healers, such as trained herbalists, informal herb sellers, sangomas, and local people record financial benefits from selling about twenty-six different plants to their customers (Bhat & Jacobs, 1995). Other works such as the Twine, Moshe, Netshiluvi & Siphugu (2003) study similarly details the significance of medicinal plant collection to household economy and livelihood production in the Limpopo Province (Twine, et al., 2003). This study shows that in the rural are of Mametja in Limpopo, the indigenous herb market contributes significantly to the local household economies of the population through the informal selling of plants in street markets and local herbal pharmacies (Twine, et al., 2003).

According to Dold & Cocks (2002), the vast majority of the benefactors of the indigenous medicine market in South Africa are women. The authors reveal that there are at least 133 000 people employed in the trade nationally, most of which are rural women (Dold & Cocks, 2002). It is estimated that 74% of medicinal plant harvesters, street traders and indigenous healers are women, and of these a staggering 80% percent are rural indigenous women (Dold & Cocks, 2002). This data shows that the main role players and benefactors of the indigenous medicine trade are predominantly rural indigenous women, thus their involvement in the indigenous medicine trade constitutes an important livelihood option for them and their families, contributing to the social and economic development of indigenous South African women and their communities.

2.5 The relationship between indigenous health and biomedicine

As literature suggests, many countries that have indigenous populations operate on national health policies that are not inclusive of the indigenous health systems of their indigenous population groups (Oliver, 2013). Oliver (2013) argues that the "impact of colonisation and the subsequent displacement and disconnection of people both from their indigenous lands and later from their families has been significant in its subsequent effect in the use of indigenous practices including indigenous medicine" and this has not been effectively addressed in the health policies of many countries around the world (Oliver 2013: 1). Oliver further mentions that The Alma-Ata declaration on primary health care (PHC) signed into action by the WHO in 1978 encouraged "several countries to improve their indigenous medicine use and regulation of use within the primary health care model" (Oliver 2013: 1). The above mentioned declaration states that "the existing gross inequality in the health status of the people, particularly between high and low income countries as well as within countries, is

politically, socially, and economically unacceptable and is, therefore should be of common concern to all countries and hence each country should make redress a top priority" (WHO, 1978).

However as Oliver argues, although the "holistic approach in the evolvement from primary medical care to primary health care as adopted by the Alma-Ata declaration has been praised, there has still been no mention of the incorporation of indigenous medicine use within the design of these health services in most countries" (Oliver 2013: 2). As the Oliver study reveals, in Australia "PHC for Aboriginal and Torres Strait Islander populations is currently addressed by either government controlled health services or community controlled health services that offer biomedical health care and employment to trained indigenous Aboriginal Health Workers (AHWs)" (Oliver 2013, 1). These healers are the health professionals who ensure the delivery of holistic and culturally appropriate healthcare to the respective indigenous communities and hence their involvement in PHC has proven to be vital in combatting disease amongst indigenous populations (Campbell & Burgess, 2011) (Oliver, 2013). Campbell & Burgess argue that although it is recognized in that in many isolated parts in Australia as well as in other countries around the world that it is possible for indigenous medicine to coexist with biomedicine as part of a varied healthcare system, however it still remains uncertain to what extent indigenous medicine is practiced in conjunction with biomedicine in most countries (Campbell & Burgess, 2011).

2.5.1 The health status of indigenous peoples globally

The WHO estimates that there are "approximately 370 million indigenous peoples living in more than 70 countries worldwide", and in all these countries the health status of indigenous populations differs considerably from those of other population groups in those countries (WHO, 2007). The organization cites marginalization and discrimination against indigenous people as the main reason why this is so (WHO, 2007). Scholars of IKS such as Harfield, Davy & Brown (2015) argue that indigenous groups in colonized countries have relatively poorer health outcomes as compared to their non-indigenous counterparts due to both a general marginalization of indigenous health strategies within mainstream health services and its inability to take into account indigenous understandings of health (Harfield, et al., 2015). The study reports some statistics on these health outcomes and cites that in Australia, "in the period 2010 to 2012 the estimated gap in life expectancy between Aboriginal and Torres Strait Islander Australians compared to non-indigenous Australians was 10 years" (Harfield, et al., 2015: 44). The study further cites similar gaps in life expectancy between indigenous and non-indigenous populations in other countries, such as New Zealand, Canada and the United States. In New Zealand, "the gap between Māori and non-Māori life expectancy at birth stands at 7.3 years, based on death rates in 2010–12. Māori life expectancy at birth reached 72.8 years for males and 76.5 years for

females in 2010–12. This compares with 80.2 years for non-Māori males and 83.7 years for non-Māori females" (New Zealand, 2013).

In Canada, the "life expectancy for the total Canadian population is projected to be 79 years for men and 83 years for women. Among the Aboriginal population the Inuit have the lowest projected life expectancy, with numbers standing at 64 years for men and 73 years for women. The Métis and First Nations populations have similar life expectancies, at 73-74 years for men and 78-80 years for women" (Canada, 2015). The Native American and Alaska Native people of the Unites States also have historically experienced lower health status when compared with other non-native Americans. Still today, Native American and Alaska Natives born today are expected to have a life expectancy that is 5.5 years less than the rest of the American population. The US Department of Health and Human Services states that "the observed lower life expectancy and the disproportionate disease burden amongst indigenous groups exist perhaps because of inadequate modern education, disproportionate poverty, discrimination in the delivery of health services, and cultural differences, which are all broad quality of life issues rooted in economic adversity and poor social conditions" (IHS, 2018). The "gap in life expectancy and the health disadvantage experienced by indigenous people is in part the result of mainstream health services not adequately meeting the health needs of indigenous people and indigenous people's inability to access mainstream services" (IWGIA 2017: 172).

2.6 Contributions made by indigenous medicine in modern medicine

Scholars of pharmacology argue that there is still a gap in scientific evidence on the cytotoxicity and pharmacokinetics of the products of indigenous medicine (Barrett, 1998). Although it is generally accepted in academia that more empirical evidence is needed to substantiate the claims of indigenous healers, the stance that only empirical evidence is scientific evidence is problematic. Some scholars of Western modern medicine hold a pessimistic view of indigenous medicine, by claiming that traditional medicines are often effective with minor health ailment and illnesses such as "diarrhoea, headaches and other pains, swellings and in sedating patients" (Freeman & Motsei 1992, 1184). Green argues that such statements make the assumption that indigenous medicine is only effective in treating minor physical ailments and hence cannot be trusted with severe physical disease in the same manner that Western medicine can, and as a result his creates a power dynamic in which Western medicine is portrayed as being superior to indigenous medicine (Green & Makhubu, 1984) (Green, 2014).

However, that is not to say that all academics view Western medicine as being superior to indigenous medicine. In fact some scholars such as Freeman and Motsei (1992) have stated that their motivation for studying the efficacy and reliability of indigenous medicine through conducting pharmacological

analyses of indigenous plants is because indigenous medicine is a reservoir of knowledge that could be beneficial to the world, since "though the proportion of pharmacologically active properties of traditional herbs is uncertain, there are clearly medicines which are effective" (Freeman & Motsei 1992: 1183). There are many riveting studies that have been conducted across the world on various indigenous medicines from various cultures, which have resulted in many novel discoveries in the field of ethnopharmacology. This section of the chapter will briefly explore some of these discoveries to show the important contribution that indigenous medicine has made in modern health science.

2.6.1 Traditional Chinese Medicine (TCM)

Chinese researchers Fu, Wang & Zhang (2014) argue that "pharmacology as a modern science was introduced in China approximately 150 years ago, and has been used since then to study traditional Chinese medicine (TCM)" (Fu, et al., 2014: 85). The field of pharmacology in China has since experienced its own development over this time and continues to provide new tools for the study of TCM (Liu, et al., 2013). The pharmacology of TCM has been studied extensively in China and around the world, leading to model discoveries that have changed the face of modern medicine (Liu, et al., 2013). Using the model of chemistry-focused study, researchers in China managed to unlock the pharmacokinetics of the indigenous plant *Herba Leonuri*. The herb, locally known as Yi Mu Cao, is a potent indigenous Chinese medicine, which has had a long history of development and application in China (Liu, et al., 2013). In particular, *Herba Leonuri* has been widely used in the treatment of gynaecological and obstetric disorders for thousands of years. A recent study conducted by Liu, Pan & Zhu (2012) with this plant has shown that *Herba Leonuri* contains several active components, including alkaloids, flavonoids, diterpenes compounds and fatty acids that contribute to this medicinal effects (Liu, et al., 2012). This study further revealed that these molecules exert beneficial effects in coronary artery disease and cerebral ischaemia, thus making these molecules novel candidates for drug discovery and development (Liu, et al., 2012).

TCM is also used in China to prevent and treat Cardio-cerebrovascular diseases (CCVD), which is one of the world's leading causes of death (Li, et al., 2003). However, although great strides have been made in the field of Chinese pharmacology, the study of indigenous medicine still creates challenges in understanding herbs at a systems level due to the complexity of the Chinese indigenous medicine system (Liu, et al., 2012). To overcome this challenge, researchers have developed a new novel model, termed traditional Chinese medicine systems pharmacology (TCMSP) analysis platform, which relies on the theory of systems pharmacology and integrates absorption, distribution, metabolism, excretion and toxicity (ADME/T) evaluation, target prediction and network/pathway analysis (Fu, et al., 2014). Systems pharmacology is a technology that is used by pharmacologists, and it utilizes the concepts of systems biology to reveal pharmaceutical actions of active compounds

which is used to guide drug discovery. Principal approaches for systems pharmacology include information integration of omics data sets, computer modelling, data analyses that focus on network analysis, and a direct experimental approach (Fu, et al., 2014). Essentially TCMSP can be broadly defined as a unique systems pharmacology platform of herbal medicines that captures the relationships between drugs, targets and diseases (Fu, et al., 2014). The database generated by this technology includes chemicals, targets and drug-target networks, and associated drug-target-disease networks, as well as pharmacokinetic properties for natural compounds involving oral bioavailability, drug-likeness, intestinal epithelial permeability, blood-brain-barrier, aqueous solubility (Ru, et al., 2014). This incredible breakthrough has sparked great interest from pharmacologists and researchers worldwide, placing a renewed interest in the efficacy of TCM in combating complex human diseases.

Due to complex discoveries like these being made by researchers, TCM has become a recognised and respected medical system both in and outside of China, and it has become an inseparable part of the Chinese public health system (Liu, et al., 2013). In recent years, TCM has gradually gained considerable approval as a complementary or alternative medicine in Western countries as well. Chinese researchers Qi, Wang and Cai (2013) argue that Chinese herbal medicine, which is the most important component of TCM, is currently used in the health care of an estimated 1.5 billion people worldwide (Qi, et al., 2013).

2.6.2 Indigenous Indian Medicine (Ayurveda)

Samy, Ignacimuthu & Sen (1999) inform that Ayurvedic medicine, also known as Ayurveda, is one of the world's oldest medical systems that is still being utilized in modern times. According to the authors, Ayurveda places its origins in India more than 3,000 years ago and still remains one of the country's most utilized indigenous health care systems, apart from Siddha and Unani (Samy, et al., 1998). Ayurvedic concepts about health and disease promote the use of herbal compounds, special diets, and other unique health practices and India's government and other institutes throughout the world support clinical and laboratory research on Ayurvedic medicine (Sheikh, et al., 2015). In India, around 20,000 medicinal plants have been recorded; however, traditional practitioners use only 7,000–7,500 plants for curing different diseases (Samy, et al., 1998). The estimated proportion of use of plants in the different Indian systems of medicine is Ayurveda 2000, Siddha 1300, Unani 1000, Homeopathy 800, Tibetan 500, Modern 200, and folk 4500 (Pandley, et al., 2013). Various studies have been conducted in India to test the efficacy and pharmacology of various indigenous medicines used by practitioners of Ayurveda to manage illness. A study by Samy, Ignacimuthu & Sen (1998) published in the *Journal of Ethnopharmacology* conducted on the medicinal plants of the tribal people

of Western Ghats, assayed a total of 34 plant species belonging to 18 different families for antibacterial activity against the gram negative bacteria *Escherichia coli, Klebsiella aerogenes, Proteus vulgaris,* and *Pseudomonas aerogenes* . Of these 34 plants tested, 16 showed activity; among them *Cassia fistula, Terminalia arjuna* and *Vitex negundo* showed significant antibacterial activity against the tested bacteria (Samy, et al., 1998). These findings confirmed the traditional therapeutic claims for these herbs and served to cement an interest in the validity of Indian indigenous medicine.

The study of indigenous Indian medicine has proven to have great ethnopharmacological relevance in multiple fields of research, including medical research, botanical research and phytochemical research to name just a few. Through collaborations with Indian indigenous healers, a 2015 study by Sheik, Maibam, Biswas, Laisharm & Borah published in the *Journal of Ethnopharmacology* identified 15 medicinal plant species traditionally used as remedies to control diabetes and provided evidence for their efficacy (Sheikh, et al., 2015). Out of the 15 plants investigated, *Ficus cunia* extract had the highest potency, followed by *Schima wallichi* and *Wendlandia glabrata* (Sheikh, et al., 2015) . This data showed that there is great potential in the pharmacological use of Indian indigenous medicine in anti-diabetic treatment. Cancer is also a major field of study in India and many of the Ayurvedic remedies have been studied extensively to investigate their pharmacological significance. *Hedychium coronarium*, popularly known as *butterfly ginger, butterfly lily, cinnamon jasmine, garland flower* and *ginger lily*, is a medicinal plant cultivated throughout India and other Southeast Asian countries, and is traditionally used to treat pain, wounds, infections and rheumatism (Endringer, et al., 2014). Findings from the Endringer, Kondrattuk, Pezuto & Braga (2014) study indicate that the cancer chemoprevention effect of *H. coronarium* most probably involve the inhibition of NF-κB, which may also account for the alleged anti-inflammatory activity of the plant. These data suggest the potential cancer chemopreventive activity of *H. coronarium* (Endringer, et al., 2014). Due to novel discoveries such as these being made, many national and multinational pharmaceutical companies are now concentrating on manufacturing of Ayurvedic Phyto-pharmaceutical products (Sheikh, et al., 2015).

2.6.3 Australian Aboriginal medicine

According to Clark, since the late nineteenth century, chemists and pharmacologists have investigated the medical potential of indigenous Australian plants (Clark, 2008). One of the plants that attracted the attention of researchers in the 1880s was the poison corkwood tree *Duboisia myoporoides,* which inland Aboriginal groups used as a narcotic and a poison (Clark, 2008). The pharmacological analysis of this species led to the discovery of nicotine alkaloids that became widely used as a mydriatic to control pupil dilation in ophthalmic surgery (Foley, 2006).

According to Australian pharmacologist Smith, many of the great discoveries that have been made in the field of Australian indigenous medicines have been the result of an unwavering interest and investment from both researchers and the Australian government (Smith, 1991). The Bush Medicine Project, which was funded through the Australian Northern Territory Department of Health and Community Services was established in 1980 and chiefly composed of pharmacologists and botanists, conducted a nation-wide survey of indigenous herbal remedies (Smith, 1991). The aim of the Medicine Project was to undertake extensive fieldwork with Aboriginal indigenous healers to compile and catalogue a listing of medicinal plant species which the research team considered to have a chemical basis to their efficacy (Smith, 1991) (Clark, 2008). The findings from this project have been corroborated through many studies that followed thereafter. In a pharmacological study published in 2003 by Li, Myers, Leach & Lin focusing on the in-vitro inhibitory effects of 33 ethanol extracts obtained from 24 medicinal Aboriginal plant species on cyclooxygenase-1 (COX-1) were evaluated and examined for chemical efficacy (Li, et al., 2003). The medicinal plants selected for this study have been used in aboriginal medicine in Australia over many generations for the treatment of various inflammatory diseases such as asthma, arthritis, rheumatism, fever, edema, infections, snakebite and related inflammatory diseases (Li, et al., 2003). All of the selected plants, with one exception, showed inhibitory activity against COX-1, which supports their traditional uses. The most potent COX-1 inhibition were observed from the leaf extracts of *Acacia ancistrocarpa*. Additionally, bark extracts of *Ficus racemosa*, stem extracts of *Clematis pickeringii*, leaf extract of *Acacia adsurgens*, stem extract of *Tinospora smilacina* and fruit powder of *Morinda citrifolia* also exhibited inhibition (Li, et al., 2003). The findings of this study provided evidence of the efficacy and reasoning of why these plants have been traditionally used for the treatment of inflammatory conditions in Australian aboriginal medicine and offered a scientific basis for the claims made by indigenous Aboriginal healers.

2.6.4 South African Indigenous Medicine

In South Africa, great discoveries have also been made in the field of ethnopharmacology. The South African plant *Sutherlandia Frutescens subspecies Microphylla*, locally known as “unwele” has been found to be effective in the treatment of cancer, tuberculosis, diabetes, chronic fatigue syndrome, influenza, rheumatoid arthritis, osteoarthritis, peptic ulcers, gastritis, reflux esophagitis, menopausal symptoms, anxiety, clinical depression and HIV infection (Gericke, et al., 2001). One of the chemical constituents of *Sutherlandia*, L-canavanine which is an arginine analogue, has been reported to have anti-viral activity against influenza and retroviruses, including HIV (Mills, et al., 2005).

Hypoxis has previously been used as an immune booster in HIV&AIDS patients, but is also being used to treat other immune related illnesses such as the common cold, flu, arthritis and cancer (Bouic, et al., 2001). Researchers have discovered that the plant contains various sterols (β-sitosterol,

stigmasterol) and their glycosides (sterolins) such as β-sitosterol glycoside and stanols such as sitostanol also called stigmastanol, which have also been purported to have important biological activity (Bouic, et al., 2001). However, there has been some concern about the toxicity of *Hypoxis*, which has been associated with important toxicities including a systemic lupus erythematous syndrome (Capasso, et al., 2000). However, researchers argue that efforts are still required to determine the safety, efficacy and pharmacological profile of the many herbal compounds used in Africa, and that collaboration with indigenous healers is justified to fully understand what remedies are in use for HIV and to educate those providing alternative medical services against unsafe practices (Mills, et al., 2005). Many studies in South Africa have been conducted in conjunction with indigenous healers and many great discoveries have been made. However, Motsei and Freeman argue that a neglected policy issue thus far has been the question of whether indigenous healers have a role to play in future health care, and if so what this should be (Freeman & Motsei, 1992).

2.7 The toxicity of indigenous medicines and the issue of safety

Throughout the world, the toxicity of herbal mixtures is of high concern. Toxicologists agree that a number of factors can contribute to the toxicity of indigenous medicines, some of which include contamination of the remedy, the erroneous identification or preparation of plants, the incorrect use of or administration of a remedy, concurrent disorders in the patient receiving the remedy, the patient's age and sex, an interaction of the remedy with other medications (Luyckx & Naicker, 2008). One of the major health concerns of using indigenous medicine is herbal intoxication, which in some cases causes severe kidney damage. Drug-induced nephrotoxicity reportedly contributes to up to 26% of cases of hospital-acquired acute kidney injury as compared to traditional remedies that contribute up to 35% of cases acute kidney injury (Luyckx & Naicker, 2008). The mortality rates of kidney damage due to traditional remedies is estimated to be between 24% and 75% (Myhre, 2000). Although the incidence and prevalence of kidney injury associated with traditional medicines varies from place to place, it is safe to assume that in Western countries with well-developed healthcare systems, a large proportion of patients with kidney injury will probably recover some renal function, with adequate supportive care such as dialysis (Joubert & Mathibe, 1989).

However, in rural settings, such as Madwaleni, where intensive care and dialysis are not available, patients with severe kidney injury are likely to die (Luyckx & Naicker, 2008). The table below, published in the *Nature* journal, showcases some of the plants that have been identified to cause kidney injury. The study was conducted by researchers Luyckx and Naiker from the Division of Nephrology at the University of Witswatersrand, South Africa. The table showcases two South African medicinal plants, *Sutherlandia frutescens* and *Callilepis laureola*, which can cause severe kidney injury if used inappropriately. *Callilepis laureola* is known locally as "impila" and is used for

ritual cleansing and purification as well as a purgative (Van Wyk, et al., 1997). However, the route and method that the herb is used greatly affects its toxicity. If “impila” is taken orally with large amounts of water and regurgitated immediately afterwards, then it is relatively safe to use as long as it is administered to patients that are above the age of 10 years old (Luyckx & Naicker, 2008) (Bodenstein, 1977). If the remedy is not taken in this way, or is administered to a child younger than 10 years old, then liver damage can occur due to increased toxicity for younger ages (Luyckx & Naicker, 2008) (Steenkamp, et al., 1999). The image is extracted from the study by Luyckx, V. & Naicker, S., 2008. Acute kidney injury associated with the use of traditional medicines. *Nature,* **4**(22), pp. 664-671.

Table 1 Specific renal pathologies associated with traditional medicines and edible plants.

Renal pathology	Traditional medicine or edible plant
Acute tubular necrosis	Cape aloe (*Aloe capensis*), chelation therapy (ethylenediaminetetraacetic acid [EDTA]), Chinese yew (*Taxus celebica*), chromium picolinate, djenkol beans (*Pithecellobium lobatum*), fish gallbladder (family Cyprinidae), germanium, hemlock (*Conium maculatum*), impila (*Callilepis laureola*), khat (*Catha edulis*), licorice (*Glycyrrhiza glabra*), L-lysine, mourning cypress (*Cupressus funebris*), pennyroyal (*Hedeoma pulegioides*), potassium dichromate, Spanish fly (*Lytta vesicatoria*), Takaout Roumia (paraphenylenediamine), wild wisteria (*Securidaca longepedunculata*), wormwood oil (*Artemisia absinthium*), yellow oleander (*Thevetia peruviana*)
Allergic/acute interstitial nephritis	Cat’s claw (*Uncaria tomentosa*), Chinese yew, CKLS (colon, kidney, liver, spleen purifier), glucosamine, propolis
Hepatorenal syndrome	Bird flower (*Crotalaria laburnifolia*), hydrazine sulfate, impila, pennyroyal
Rhabdomyolysis	Creatine, Chinese herbs (*Aristolochia* spp.), Ma Huang (*Ephedra sinica*), hemlock, licorice, Takaout Roumia, wormwood oil
Renal tubular acidosis	Coneflower (*Echinacea* spp.)
Fanconi’s syndrome	Chinese herbs, L-lysine, bladderwrack (*Fucus vesiculosus*), licorice
Diabetes insipidus	Bladderwrack
Nephrotic syndrome (glomerular injury)	Mercury-based skin-lightening creams, contaminated bladderwrack, yellow oleander
Interstitial fibrosis	Bladderwrack, Chinese herbs, chromium picolinate, germanium, licorice, mesotherapy, rhubarb (*Rhizoma rhei*), St John’s wort (*Hypericum perforatum*), willow bark (*Salix daphnoides*)
Kidney stones/obstruction	Djenkol beans, Ma Huang, rhubarb, star fruit (*Averrhoa carambola*), cranberry (*Oxycoccos* spp.) juice
Papillary necrosis	Willow bark
Transplant rejection	Alfalfa (*Medicago sativa*) and black cohosh (*Actaea racemosa*) (when taken together), St John’s wort
Renal cysts	Chaparral (*Larrea tridentata*)
Urothelial malignancy	Chaparral, Chinese herbs

Image 1: A table showcasing some of the known traditional medicines that have been discovered to cause kidney injury when used inappropriately.

2.7.1 Toxicity of indigenous medicine in South Africa

Despite routine use of about 400 medicinal plants in South Africa, the pharmacological implications of some of these plants still remain unknown (Mills, et al., 2005). The use of indigenous medicines has had fatal consequences, but the precise number of all herb-induced fatalities in South Africa is still unknown as many have not been recorded or investigated (Bye & Dutton, 1991). In terms of the local herb known as "impila", some statistics do exist. In the mid-70s, Wainright and Schonland reported a high incidence of centrilobular liver necrosis in black people residing in KwaZulu Natal. They reported that accompanied by renal necrosis, this liver damage accounted for 2% of all deaths at the King Edward VIII Hospital over the period of 1958-1977 (Wainwright, et al., 1977). In all these cases, *impila* was identified as the causative agent. By the 1980s, a later study revealed that in total some 260 deaths, a third of which were in children under the age of five years, had been attributed to the use of *impila* (Bhoola, 1983). Some symptoms that were observed included vomiting, jaundice, abdominal pain and convulsions, also hypoglycaemia and uraemia were often present in these cases (Bhoola, 1983). A 1989 study by Joubert and Mathibe revealed that poisoning by ingesting indigenous medicine was the second most common cause of acute poisoning representing 12.1% in South Africa at that time (Joubert & Mathibe, 1989).

Five years prior, researchers Joubert and Sebata (1982) had reported 277 cases of acute poisoning cases of patients admitted to Ga-Rankuwa hospital (Gauteng Province, South Africa) between 1981 and 1982, of which 18% were due to ingestion of toxic indigenous medicines. It was reported that 26% of these poisonings resulted in death (Joubert & Sebata, 1982). Years later, Venter and Joubert (1988) reported an increase in these incidents, reporting that 1306 patients were admitted to Ga-Rankuwa Hospital in Gauteng due to acute poisoning in the period of 1981-1985, out of which 15.8% were from the use of indigenous medicines (Venter & Joubert, 1988). This study further revealed that poisoning from indigenous medicine resulted in a 15.2% mortality rate and accounted for 51.7% of all deaths in the hospital (Venter & Joubert, 1988). As this data shows, South African indigenous herbs have a long history of fatal herbal intoxication, and hence more work still needs to be done in terms of testing their safety and efficacy.

2.7.2 Moving forward towards bridging the knowledge gap

The danger of using herbal remedies is of real concern in South Africa and globally. However, researchers agree that more work is needed in the field of ethnopharmacology to unpack and to

understand the uses of indigenous medicines and how they can be better regulated (Bhoola, 1983). Australian pharmacologists Shahid and Thompson argue that the fear of toxicity is not what drives people away from using indigenous remedies, rather the concern over interactions between pharmaceutical medicines and bush medicines is a reason for not wanting to use bush medicines (Shahid, et al., 2010). Both researchers argues that instead of blatantly citing indigenous medicine as "unsafe", the area of uncertainty for drug-plant interactions should be considered from the other perspective also – that is non-compliance of pharmaceutical medicine due to a desire to use bush medicine and not wanting to mix the two (Shahid, et al., 2010). Oliver reports that as a means to reach this goal, in the 1970s the concept of 'two ways' was introduced in the Northern Territory of Australia, which had the aim of incorporating both indigenous healthcare and biomedical healthcare, however was dismissed by the late 1990s for reasons unknown (Oliver, 2013). As research has shown, indigenous patients do desire to effectively use both Western and indigenous methods of healing in the management of illness (Mji, 2013) (Mokgobi, 2014). As Oliver, Williams and Thompson argue, integration can be viewed as not only the combination of pharmaceutical and plant medicine but also the combination of indigenous healers and western medical doctors (Oliver, 2013) (Williams, et al., 2011). For this to work, integration of both systems requires an understanding of the social and cultural constructions of each medical system and the complexity of the whole (Oliver, 2013).

In South Africa, the road towards integration has proven to be long and challenging because the majority of indigenous healers are situated and practice in rural communities in the country, distanced from hospitals and clinics where biomedical professionals work, making collaboration challenging. Many indigenous healers operate within their communities and the knowledge they hold remains within those spaces. The challenge of accessing this knowledge is that few studies have aimed at documenting the life stories, medical experiences and health perspectives of rural South African indigenous healers within the cultural understandings in which they operate (King, 2012). A firm step in bridging the knowledge gap is to conduct more studies that aim to explore indigenous healers and the illnesses they manage within their cultural understandings of health and illness within their communities and the cultural landscapes in which they operate.

2.8 Moving forward with indigenous health knowledge (IHK) studies in Pharmacology:

Throughout South Africa, the cultural and spiritual meaning of nature and its link to health among indigenous people is poorly recorded and is often misunderstood (Dold & Cocks, 2012). Etkin articulates that much of what is reported as ethnopharmacological research is comprised by decontextualized catalogues of plants and lists of pharmacologic properties and few researchers seem to be interested in the people whose knowledge and identity are embodied in these plants. Most of

what is published as Ethnopharmacology has weak, if any, ethnographic component (Etkin & Elisabetsky, 2005). The point that Etkin is emphasizing is that the ethnographic investigation of the exact roles of indigenous healers, as well as a thorough analysis of their beliefs, methods and practices is particularly important in developing our deep understanding of what we call "Ethnopharmacology". According to Etkin, it is not enough to just study indigenous medicinal plants alone and not also study the indigenous belief systems that govern the use of those plants (Etkin & Elisabetsky, 2005). However, there is a gap in the literature in terms of studies that are aimed at documenting both the belief systems of indigenous healers in conjunction with their herbs and plants. As proposed in Mji's study, there is a need to fill this knowledge gap by conducting ethnopharmacological explorations of indigenous healers, the medical plants they use to manage illness as well as the belief systems this knowledge is based on (Mji, 2013).

2.9 Summary of the chapter:

This chapter provided an in depth analysis of the research question, with the intention of creating a platform for both global and local worldviews about the field of indigenous health knowledge to be analysed. The chapter was organized in a manner in which the first point of analysis was the concept of indigenous health knowledge (IHK), which then proceeded to an analysis of the significance of IHK in global health and the contributions made by IHK in global modern health science. A further analysis of some of the riveting issues that have resulted from the use of indigenous medicine was given with the purpose of exploring the dangers that have previously been associated with the improper use of the products of indigenous plants.

CHAPTER 3

METHODOLOGY

3.1 Introduction

This chapter serves as the methodology chapter of this thesis. It provides an in-depth description of the qualitative research techniques and strategies that were used to conduct this study. In this section, a description of how data was collected, analysed and validated is given within the context of the study. Additionally, these techniques are placed to fit within the study objectives which were used to guide the various steps of this methodology. In this section, examples from published literature that describe qualitative research methodologies and that informed the methodology of this study are given and described. As this is an ethnographic methodology whereby the researcher observed and learned from participants, a bottom up cyclic approach was used whereby as the investigator was being informed by the context and its participants, she was continuously adjusting the methodology to align itself with an indigenous lens of observing and describing the participant responses to key research questions. These indigenous methods of enquiry were constantly being developed, improved and fine-tuned by the investigator throughout the course of the study.

3.2 Study design

This is a descriptive, ethnographic study that used qualitative methods of data collection, analysis and presentation. The study was conducted in a diachronic manner which included participant observation, where participants took part in in depth interviews and Focus Group discussions (FGDs).

This study can be classified as a qualitative and descriptive ethnographic study because according to qualitative researchers Bricki & Green, qualitative research is characterised by its aims, which relate to understanding some aspect of social life, and its methods which generate words, rather than numbers, as data for analysis (Bricki & Green, 2007). Taking a note from Bricki & Green, this study aimed to understand the intricate aspects of amaBomvana social life and health, and the research methods used generated words rather than numbers and then tabulated that data and described it, as is fitting for a descriptive study. This study can appropriately be called descriptive because descriptive studies describe events and then organizes, tabulates and depicts the data collected (Glass & Hopkins, 1984). Renowned qualitative researchers such as Glass and Hopkins cite that tables and figures are some of the common visual aids used to help the reader understand the findings of a descriptive study, hence their use in this study to present the data (Glass & Hopkins, 1984).

3.2.1 Using the investigator as an instrument:

This ethnographic study is one in which the instrument used to gather data was the investigator, and it made use of a research method that attempts to study the socio-cultural contexts, processes, and meanings within cultural systems (Whitehead, 2004). Qualitative researcher Whitehead describes in her training guide titled *What is Ethnography? Methodological, Ontological, and Epistemological Attributes* (2004) that the reason for stating that the investigator in ethnographic research is an instrument to gather data is because she also along with her participants participates in the interviews, makes observations of the naturally occurring events, and provides an analysis of the phenomena occurring naturally without trying to control any of the variables as this would destroy the phenomena being observed (Whitehead, 2004). The investigator followed this approach and positioned herself as part of discussions, events and activities throughout the data collection process.

Recent studies in which the investigator has been used as an instrument include works done by Bahrami and Pezzela. The Bahrami (2015) study found that investigators in qualitative studies have the main role, especially in data gathering. Brahmi even claims that actually the experiences and skills of the investigator, the ability to communicate and asking the right questions are some of the most important factors that validate the data (Bahrami, 2015). Following that same line of thought, Pezella, Pettigrew and Miller-Day (2012) note that the figure of the investigator as the instrument for qualitative data collection has been widely acknowledged amongst qualitative researchers (Pezella, et al., 2012). The authors argue that because the investigator is the instrument in semi-structured or unstructured qualitative interviews, unique investigator attributes such as personality have the potential to influence the collection of empirical materials (Pezella, et al., 2012). Because of the highly socio-anthropological nature of this study, these published works have inspired the approach of this study for using the investigator as an instrument as she needed to immerse herself in the research site to be able to qualitatively describe the phenomenon.

3.2.2 Using indigenous techniques for conducting research:

This study is an indigenous study, meaning that indigenous practices of research were utilized by the investigator to collect data, understand the observations she was making and to reflect on what she had seen and heard. This means that firstly the investigator had to immerse herself in the culture of the people and become part of the community as a means of learning how in the amaBomvana indigenous setting people behave, move in spaces and reflect on events of the day. This required her to live full

time in Madwaleni and to be visible in all community gatherings and events as is expected of a community member.

Secondarily, the amaBomvana people of Madwaleni have their own system of neatly designed, tried and tested methodologies of engaging people in group spaces, of how to conduct interviews and of participating in community gatherings. Mji (2013) noted this system in her work with the older elite Xhosa women of Madwaleni. Mji noted that the older amaBomvana women expect the younger members of the community to participate in the activities of the household such as collecting firewood, cooking, cleaning and looking after the livestock as a means of learning. In this indigenous education system, teachings are experimental and practical, carried by word of mouth and not written down. This is the indigenous Bomvana concept of receiving an education (Mji, 2013). The investigator had to learn these indigenous practices of collecting information by consulting with indigenous leadership, attending community gatherings to observe how people share space and communicate with one another, and by actively participating in activities in the community in order to gain a deeper understanding. Some of these tasks and activities included helping with cooking at community gatherings, assisting in collecting drinking water from communal taps, assisting neighbours with gardening, which all served as data collection and validation. A description of those indigenous techniques will be given in this chapter within the context of each of the study objectives.

3.3 Study setting

An in-depth description of the study setting is given in Chapter 1, the introductory chapter of this thesis. In this section, the investigator will not repeat the information already given, but will highlight how she organized herself in the study area during the course of this study by striving to become an insider who was part and parcel of the community.

3.3.1 Making Madwaleni home:

For the purpose of this study, the investigator moved into the area of Madwaleni full time during the course of data collection, where the Donald Woods Foundation in Hobeni village became her home. The reason why the investigator decided it was best to live in the study area was because she wanted to fully understand the amaBomvana indigenous healers, their ways of doing things, their understandings of their environment, their connection to spiritual beings, and the relationships they have with the plants and animals of their land. The investigator felt that the best way to achieve that was by becoming a part of the community. The impetus driving the investigator was not to make the amaBomvana indigenous healers feel like they were study subjects, but to make them feel like they were co-investigators that were also learning, growing, and stepping into spaces of more

understanding along with the investigator herself. This process allowed the investigator to become a participator in the research and not just a describer of phenomena and events. Additionally, moving to Madwaleni allowed the investigator to become an insider that lived the experiences of being a part of kwaBomvana, and not merely an outsider looking in to observe and to document Bomvana life.

Qualitative researchers Raheim, Magnussen & Blystad (2016) attest that the insider-outsider perspective in qualitative studies is not something new (Raheim, et al., 2016). The authors state that the key importance of this technique is that it revolves around researcher positionality, what it means to be an insider or outsider in a given study setting, and how the researcher's status is negotiated throughout the research processes (Raheim, et al., 2016). For this study, the investigator was aware that she was an outsider coming from a different community to join a new community so that she could gain an insider perspective. This dynamic allowed her to be better sensitive to the unequal power dynamics she was bringing in as somebody who is affiliated with a university, someone who is not Bomvana and as somebody who had resources that the rest of the community might not have such as a formal education. Therefore, becoming an active member of the community that lived, engaged and shared experiences with the community on a daily basis allowed the investigator to position herself as someone who was interested in the amaBomvana not just for their knowledge, but as someone who truly cared about the upliftment of the community.

3.3.2 Becoming a part of the amaBomvana indigenous healers:

As part of the process of becoming an insider, the investigator aligned herself with the indigenous healers of Madwaleni. She started off by visiting some indigenous healers in their homes for tea as means of forming personal relationships. These tea visits were meant to be relaxed and jovial, with both parties getting to know one another. During these tea visits, the investigator would assist with chores that were being performed in her host household such as collecting firewood and cooking meals. As these relationships blossomed, the investigator was invited to join indigenous healer gatherings in which the healers got together and prayed, danced and connected to their ancestral spirits. This process allowed the investigator to become part of the inner circle of indigenous healers as she had to learn the amaBomvana ways of doing indigenous healing. Consequently, this process also allowed her to gain the respect of the healers. As a means of gaining trust and respect from the healers, the investigator participated along with them in community prayer ceremonies, sacrificial healing rituals and trips to harvest medicinal plants and herbs.

Secondarily, as a sign of respect to one another, the indigenous healers of Madwaleni refer to one another by their spiritual names instead of by their birth names. These spiritual names are called "igama lobugqirha" which means "the name the ancestors have given". As a sign that the healers had

accepted the investigator as one of their own, she was referred to by her spiritual name "Ntombecamagu" which means "Daughter of Peace" instead of her birth name, which is Thando.

3.3.3 Community entry

The investigator was assisted to enter Madwaleni by the Donald Woods Foundation (DWF) in the village of Hobeni, which eventually became her home for the duration of the study. The organization is committed to bringing 'health to every hut' by integrating the 'accessibility' principle of Primary Health Care, which is accessibility to basic health services (Foundation, 2017). The DWF granted the investigator a room and transportation to travel to the villages around the Madwaleni area, as well as the hospital and 9 clinics. The foundation is equipped with running water, electricity and security services which provided a sense of comfort and security for the investigator.

The Chiefs of Hobeni and Nkanya assisted the investigator in entering the realm of the indigenous healers by referring her to their trusted personal indigenous health practitioners, who later became key informants in this study.

The investigator was introduced to the realm of the elite older Xhosa women by Professor Gubela Mji, who is also her supervisor for this study. Mji has spent many years in the area of Madwaleni conducting research for her PhD dissertation, and hence served as a valuable asset in the investigator's initial efforts of community entry. Professor Mji also assisted with understanding the culture of the amaBomvana as she had spent many years engaging with the amaBomvana on both personal and professional levels.

3.3.4 Study population

The study population was made up of two main groups:

a. The indigenous health practitioners and indigenous leaders from the villages mentioned in the study setting.
b. The biomedical health professionals from the secondary hospital and 9 clinics.

3.3.4.1 Study sample and sampling methods

The total study sample was made up of 37 participants and key stakeholders, 30 being practitioners of indigenous medicine, 5 being biomedical health professionals, and 2 being traditional leaders. Of the 37 participants, 24 were females and 13 were males. All participants voluntarily participated and were drawn from the villages in the study setting. Firstly, the local Chiefs of Hobeni and Nkanya selected

the key indigenous healers to be contacted in their respective villages. Snowball sampling was used in which the indigenous healers identified other healers who could participate. The main inclusion criteria were that they should be practitioners of indigenous medicine above the age of 18 years.

The study sample was comprised of adults between the ages of 18 and 85 years. Although there are indigenous healers of younger ages in Madwaleni, the reason for not including them in this research was due to ethical reasons, as children cannot legally consent on their own without the approval of a guardian. The selection criteria did not limit gender or socio-economic background, and yet most of the participants happened to be from low-income, illiterate backgrounds. It needs to be emphasized that enrolment attempts had also been made to include participants from a wider demographic spectrum including those that are more resourced socio-economically, but none were found.

3.4 Data Collection and Instrumentation: Using the study objectives as a framework for the Methodology

In this study, the study objectives were used to create the overarching framework for the study methodology. This means that each study objective was addressed using approaches that were designed specifically to produce outcomes that served to answer that objective. For example, the objective of identifying and describing the indigenous healers of Madwaleni had its own unique methodological techniques that were applied to meet the objective, whereas the objective of cataloguing the medicinal plants had its own techniques that were applied to meet that objective. In this section, the techniques and approaches used to meet each study objective are explained in detail using the objectives themselves as primary headings.

1. Study objective: Describing the indigenous healers of Madwaleni and the illnesses they manage

This objective was met by conducting 8 FGDs and 4 in-depth interviews with indigenous healers. Interviews were conducted with the elderly healers only, and in their homes because these healers could not attend group discussions due to old age. Reason for doing so is because the indigenous culture of the amaBomvana demands that the eldest members of any group be given the highest respect and dignity at all times. This process is called *ukuhlonipha* and the investigator adhered to it firmly.

FGDs held in Hobeni village were hosted at the Donald Woods Foundation (DWF), in a hut with resources for making tea and snacks. Healers who attended FGDs at the DWF were from the villages

of Hobeni, Cwebe, Manganyela and Makhamezwe since these villages are closer to each other. FGDs in Nkanya, Xanase and Qatywa were held at the local Nkanya Community Hall, near the Nkanya clinic although it was difficult to reach these areas due to lack of transport. FGDs in Xorha were held at the home of a local indigenous healer since it was considered more comfortable by the participants than the local municipality hall.

A. Selecting participants:

The participant cohort for this study objective consisted of 13 amaGqirha (from which 5 were older elite women as well), 4 faith healers, 5 amaXhwele and 3 amaTola healers, totalling to 25 indigenous healers. Less focus was placed on the realm of the older elite women as Mji (2013) had already expanded extensively on this space in her work. Participants were selected through a process of snowballing technique, where indigenous healers informed other indigenous healers about the study. The key informant for this cohort was selected through the assistance of the local Chief. The reason for doing so is because the amaBomvana people place very high faith in their indigenous leaders. By having the Chief select a key representative for the indigenous healers in the FGDs provided them with a sense of safety and reassurance that their knowledge would not be abused by the research in any way.

The initial focus for selecting this cohort was on indigenous healers that have undergone, or are currently undergoing formal training to become professional indigenous healers through the laws of ukuthwasa of the amaBomvana. However, after consulting with the Chief, it became apparent to the investigator that it was important to include all types of healers, whether they have undergone ukuthwasa or not, as means of maintain social cohesion and healthy relationships. Indigenous amaBomvana methods of engaging people in research demand that the community not be polarized by the research in any way. Choosing certain people while excluding others creates spaces of unhealthy tension and envy which could potentially lead to infighting within that group. To avoid this and to adhere to cultural expectations of engaging groups of people, the investigator chose to include all indigenous practitioners of indigenous health knowledge, regardless of the schooling methods that was used in their training. The total sample for this objective comprised of 9 males and 16 females.

B. Conducting the FGDs and interviews with indigenous healers:

The initial FGD for this cohort involved getting participants to get to know one another and to get to know the investigator on a personal level. This included having the investigator share her life story, detailing where she grew up, describing her family and upbringing, and detailing how she became an indigenous healer who is also a biomedical scientist and how she navigates these two spaces. It was very important to do this because the indigenous amaBomvana culture requires that before

professional relationships can be made, personal relationships must first be established and solidified. To pay respect to the culture and to build these personal relationships, the investigator designed strategies that were intended to build trust and relax everyone that was present during the FGDs. These strategies were:

a. Everyone had to sit in a circle so that nobody's back was facing another person. This technique is based on the indigenous Bomvana belief that having your back to someone creates bad energy and leads to conflict and resentment. When you look someone in the eye and your body is facing them, you invite good energy that will bring health and friendship.
b. Each person present got an opportunity to share their personal journey towards becoming an indigenous healer. Each person was given a chance to share stories from their childhood and adulthood that motivated them to become an indigenous health care professional. This was done with the intention to practice the indigenous method of building healthy working relationships through getting to know one another on a personal level.
c. Because the investigator is also an indigenous healer, she also attended gatherings called *intlombe* as part of conducting FGDs. An *intlombe* is a social religious gathering hosted and conducted by indigenous healers. The gathering takes place in a particular home in the community that requires healing and support, and can also be conducted at the river and forests. The intention of the *intlombe* is to heal and rebuild broken relationships within families in the community. In these events, the investigator assisted with the singing and praying as is required of an indigenous healer. In these gatherings, the investigator engaged the healers in conversation about what ceremony was being conducted and why, how a family is selected for an *intlombe*, and what healing techniques were going to be utilized for the *intlombe*. All of these experiences counted as part of data collection for this study.
d. The in-depth interviews, which took place in the homes of the eldest indigenous healers who could no longer attend social gatherings due to old age, also required planning and execution of indigenous methods. For each interview, the investigator brought tea, milk, sugar and bread for making sandwiches for the participant and the family. This was done because according to amaBomvana culture, it is a requirement that when you visit someone's house, you be offered tea. The investigator kept in mind that this might be an expense for the participant, so she opted to bring the refreshments herself. This was done to ensure that the study was being both culturally sensitive and economically sensitive to the participant.
e. In the interviews, the investigator had to keep in mind that indigenous healers that are elders are not supposed to be drilled and questioned about their practice according to amaBomvana culture as doing so symbolises disrespect and creates the idea that the elder's knowledge is being doubted. This meant that the investigator had to be cautious of not bombarding the participant with questions and demanding answers as this was not culturally appropriate.

Instead, the investigator took the role of being a daughter and conducted the interview in the form of a discussion between mother and daughter. It needs to be emphasized that instead of asking individual-based questions with the hope of gaining individual-based answers, the investigator asked about more the community and the collective as means of respecting the elder's knowledge. This included a revised interview guide that consisted of questions that will drive the conversation towards:

- What is the role of indigenous healers in the community?
- What medicines and health strategies play a role in keeping people healthy?
- What is the importance of preserving inkcubeko (cultural knowledge)?
- What can the younger generation learn from the older generation about health?

Ethical considerations:

These techniques allowed the investigator to study the indigenous healers of Madwaleni within the cultural contexts in which they operate. This required adopting a methodology that was designed to uphold and to respect amaBomvana indigenous methods of engaging people in dialogue, of participating in events, and of collecting data in a manner that is culturally appropriate.

2. **Study objective: Describe and catalogue the herbs (ethnobotanical diversity) used by these healers to treat each illness, and the precise ethnobotanical environments in which these herbs grow. Secondarily, describe the relationship the healers have with these environments.**

This objective was met by conducting 3 FGDs with indigenous healers and 2 in-depth interviews with the royal Chiefs of Hobeni and Nkanya consecutively. The study group consisted of the Chiefs of Hobeni and Nkanya who were both males, 14 indigenous healers from which 8 were female and 2 were male, and 4 were elite older women who were also practising as amaGqirha. Participants were from the villages of Hobeni, Manganyela, Cwebe, Makhamezwe, Qatywa, and Nkanya. In total, the study population comprised of 4 males and 12 females (16 participants).

A. Selecting participants:

Participants for this study objective included 14 indigenous healers from the same cohort as the participants from the first objective. The reason why participants were repeated was because personal relationships had already been established with these participants and a professional relationship established. Secondarily, these participants had already built trust with the investigator and therefore

felt safe to engage in FGDs and to share information. Because the investigator had to put in a lot of work into building relationships based on trust, it was not possible to explore all the questions she had about indigenous healers in one sitting, so she had to repeatedly engage in spaces of discussions and interaction with the healers and gradually ask these questions over time.

The focus for this objective was on participants that had knowledge about the indigenous medicinal herbs and plants of Madwaleni and where these herbs grow. These included the local chiefs and indigenous health practitioners, some of whom have undergone formal training to become indigenous healers through the laws of ukuthwasa in the area of Madwaleni, and some of whom have not undergone any formal training but are knowledgeable in the indigenous medicinal plants and herbs of Madwaleni.

B. Conducting in-depth interviews with the Chiefs:

In indigenous amaBomvana culture, it is custom to pay the highest respect to indigenous leaders at all times. Indigenous leaders cannot be summoned into public spaces unless it is a cultural ceremony or ritual. Therefore, the investigator had to keep this in mind when requesting a meeting with the Chiefs. As a result of this, the Chiefs could only be engaged in in-depth interviews within the comfort of the royal residence because of their social position. As the leaders of their communities, the investigator had to conduct the interviews in the privacy of the Chief's home in the presence of his chief advisor as a sign of respect. The chief advisors had to be present because the culture of the amaBomvana requires Chiefs to be accompanied by a member of his advisory committee at all times when he is engaging in meetings of any kind.

The custom of *ukuhlonipha* had to be adhered to at all times during the interviews with the Chiefs. This custom, which dictates how a female is supposed to dress and act in the community also dictates how a female is to act and dress in in the presence of royalty. For the interviews with the chiefs, the investigator, being female, developed strategies for adhering to *ukuhlonipha*. These included:

1. The investigator had to wear long dresses that covered her legs when at the royal residences. The dress code also included the investigator covering her shoulders with a scarf or shawl.
2. The investigator was accompanied by an older male staff member from the Donald Woods Foundation when visiting the royal residence. This was done because it is customary for the amaBomvana for a young female to be accompanied by her father or an older male relative when meeting with a Chief.
3. The investigator had to allow the male staff member from the DWF to address the Chief first. This was done because it is customary for males to address the Chief first and to introduce the female. After the Chief was addressed by the male companion, then the investigator could introduce her study in detail.

4. It is customary that the questions that are addressed at Chiefs have to be followed by the proclamation “Ah! Great One!” as a sign of respect. Therefore, the investigator had to ask each question appropriately, followed by this proclamation. The questions that were addressed to the Chiefs were:
    - What is the indigenous health system in your community, Ah! Great One!?
    - Who are the indigenous healers in your community, Ah! Great One!?
    - What are some of the challenges facing the community in terms of health, Ah! Great One!?
    - How can these challenges be resolved, Ah! Great One!?

C. Conducting FGDs with indigenous healers:

The protocol for conducting FGDs with indigenous healers was adjusted slightly from the protocol described for the first objective. At this stage of the study, the healers and the investigator had already built a working personal relationship and she was trusted and welcomed by the indigenous healers into their inner circles. To meet the study objective of describing the relationship indigenous healers have with their natural environment, the investigator had to participate in sacred ceremonies and rituals being conducted by indigenous healers in these spaces. This meant that the investigator could assist in hosting some of the *intlombe* rituals and not merely be an observer. Not being an observer meant she could fully be an active participant in the ceremonies and rituals and offer prayers and offerings to the ancestors. These ceremonies were held at the river, the forest and in the homes of the people of Madwaleni and so provided a first look glance at the indigenous health strategies utilized by the indigenous healers. The investigator took full advantage of these opportunities and fully immersed herself in the ceremonies as part of her data collection. These ceremonies counted as FGDs for this study as they provided a space for the healers and the investigator to discuss and dialogue around the issues that are affecting the survival of these important ceremonial health strategies. During the ceremonies, the healers asked the investigator not to record any of the material via Dictaphone or camera, as it was considered disrespectful to the ancestral spirits that were being beckoned. For the sake of safeguarding the integrity of the data, the investigator used field notes to document these discussions and events.

The strategies used by the investigator during the *intlombe* gatherings were as follows:

1. The investigator wore only skirts and dresses that covered her knees but did not restrict her movement. This was necessary as some of the activities of the *intlombe* required the investigator to partake in cultural dancing known as *Umxhentso.*

2. The investigator wore a head scarf at all times when attending an *intlombe* gathering. The reason for doing this is because the indigenous amaBomvana culture dictates that women are to cover their heads when engaging in spaces of sacred prayer and communication with the ancestors.
3. The investigator could not participate or attend *intlombe* gatherings during her menstrual periods. The reason for this is that it is considered disrespectful for a woman in her periods to engage in sacred spaces where the ancestors reside. During her periods, the investigator could not visit the river, the forest or the family gardens where the medicinal plants of Madwaleni grow. This is forbidden, therefore the investigator had to plan both her FGDs for the *intlombe* gatherings and her cataloguing of indigenous plants around her menstrual cycle.
4. The investigator travelled to the forest to take photographs of the indigenous medicinal plants and herbs in the natural environments in which they grow, and this was achieved only on the days in which she was not on her period. Pictures of the environments themselves were also taken, and these included rivers, oceans, forest ravines, caves and open fields.

3. Study objective: Describe how the indigenous healers of Madwaleni and health professionals could work together including the process and steps to be taken to improve the relationship.

Both indigenous and biomedical professionals participated in the investigation of this study objective, with 15 indigenous healers and 5 biomedical professionals participating. The healers participated in 2 FGDs, and the biomedical professionals participated in 2 FGDs. The study population comprised of 6 males and 14 females.

A. Selecting participants:

Indigenous healers were selected from the already existing cohort of healers in the study. The primary focus for this objective was to select healers that have experienced apprehensive encounters with biomedical professionals, whether in the clinics or at the hospital. The reason for doing so was to collect data regarding how some of these tensions accumulated, how they can be reconciled and what steps need to be taken towards that reconciliation process. Out of the 30 indigenous healers that were participating in the study, only 15 had experienced conflict with biomedical professionals.

The focus for biomedical professionals was on participants who have operated as biomedical nurses and doctors in the area of Madwaleni for a substantial amount of time and who thus could shed light on some of the challenges they have encountered with indigenous medicine in the area. The reason for

doing so was to collect data from the biomedical professionals that have had first-hand experiences with indigenous healers and their health care strategies they use on patients.

B. Conducting FGDs with the biomedical professionals:

The biomedical professionals participated in FGDs but under time constraints, hence only 2 FGDs took place with biomedical professionals. The time constraints were due to the fact that the hospital has only 10 doctors and very few nurses that are available to work, meaning that getting the biomedical professionals from the hospital together in a FGDs was a challenge due to lack of available staff. Nurses from the Hobeni and Xhora clinics were chosen because they were able to sit down for FGDs as these clinics have a substantial number of nursing staff and hence the challenge of conducting a FGD could be negotiated. In critically understaffed clinics such as Nkanya Clinic where there is only 1 nurse working, whereas there are supposed to be 5 nurses, conducting a FGD was incredibly challenging. Due to all these challenges, subsequently only 5 biomedical professionals in total could commit to participating in this study.

For the biomedical professionals, questions discussed at the FGDs included**:**

- As a biomedical professional, what is your understanding of amaBomvana indigenous medicine?
- What have been your experiences with indigenous healers and your patients?
- In what ways do you see a partnership forming between biomedicine and indigenous healers in Madwaleni?

Ethical considerations:

These FGDs were short for this group because of time constraints. The clinics are usually very busy and overcrowded, making it extremely challenging for nurses to sit down for a FGD. To remain ethically sensitive, the investigator took only 20-25 minutes for each FGD so as to not take up too much time from the duties of the biomedical professionals.

C. Conducting the FGDs with indigenous healers:

For this study objective, the indigenous healers were asked to share their own personal encounters with biomedical professionals at the clinics and hospital. The healers were asked to share any interactions or opinions they have about biomedicine and its influence in Madwaleni.

The discussions questions were:

1. Your experience with biomedicine: How do indigenous healers manage or treat illness differently from biomedical professionals at the clinic and hospital? How has this difference affected you personally?
2. Relationship with biomedicine: What is your relationship with the clinics and the hospital? Do you refer patients to the clinic or hospital- if so, how are they received by the biomedical professionals? How can the relationship between indigenous healers and biomedical professionals improve?
3. Potential improvement to health care in your community: In your opinion, in what way can indigenous healers and their knowledge of indigenous medicine be integrated into the current health care system in your community? Do you see a future where this can happen?

Ethical considerations:

The investigator kept in mind that some of these experiences might be traumatic for the indigenous healers to recount, so she provided spaces for debriefing and support in case some participants felt uncomfortable with the questioning.

Overall summary of Data Collection process:

Each one-on-one interview took place at a venue of the participant's choice with adequate privacy. Venues chosen for this study included the Donald Woods Foundation (DWF), local royal residences of Hobeni and Nkanya, the Nkanya Community Hall, as well as the homes of some of the indigenous healers. FGDs were held in a shared space with the indigenous healers of that particular village. Participants were interviewed by the investigator and were audio-recorded using a Dictaphone with the participant's consent. An interview guide, complied by the investigator was used during the interviews and FGDs (see appendix D). All participants signed consent forms (ref # S17/05/11).

The royal Chiefs participated in in-depth interviews. The indigenous healers mostly participated in FGDs for this study, and only 4 in-depth interviews were conducted with this cohort. Biomedical professionals participated in 2 FGDs. Only those indigenous healers that consented to participating in the study were invited to engage in the subsequent remaining FGDs for the study. This meant that there was a repetition of participation for participants for different objectives of the study. For example, the participants who participated in the FGDs designed to meet the study objective of identifying who the indigenous healers are, also participated in the FGDs that served to meet the study objective of describing the plants and herbs of Madwaleni. In summary the FGDs were designed to meet the study objectives in this manner described in this section.

In total, 6 in-depth interviews and 15 focus group discussions (FGDs) were conducted for this study. The number of participants in each focus group discussion varied from between 5 and 8 participants. A pseudonym of the participant's choosing was used for each participant, except on the consent forms, which were additionally stored separately to retain anonymity and privacy. No actual names were used in presenting this study. All names used in the data presentation are pseudonyms. Upon each first meeting, a casual conversation was held to help the participant gain more information about the investigator's background so that the participant could feel relaxed and at ease in the presence of the investigator.

Photographs of the herbs and plants of Madwaleni were taken using a Nikon camera.

The protocol of behaviour known as *ukuhlonipha*, whereby women are expected to show respect to the ancestors and the men of the community was utilized in the methodological design of this study.

3.5 Application of rigour

In qualitative research, the concept of rigour is applied as a means of showing the trustworthiness of the data collected (Mji, 2013). The rigour applied in this study includes qualitative research concepts such as credibility and transferability.

3.5.1 Credibility

Respondent validation: The technique of cross-reading the interview text back to the participants in order to validate the use of text and language in the transcripts was used as a means of applying credibility to the data. This occurred during the period of data collection when feedback was obtained from the participants about the accuracy of the data they had given, and also the investigator's interpretation of that data. This method was derived from the works of Bricki & Green (2007) in which the authors advise that this technique is an ideal validation tool because it allows the participant to correct and amend any text that was taken out of context and to reaffirm their original intention and remarks (Bricki & Green, 2007).

Triangulation: Voice recording, photographs (digital data) and interview data (qualitative data) methods were triangulated so that diverse viewpoints would shed more light around the topics being investigated. The investigator listened to excerpts from the interviews to analyse the relationship of the interviewer and interviewee during the interview to make sure that the findings are based on the participants' narratives and words rather than potential investigator biases. This was based on the tone and inflection present in their voices. Hearing the pauses, sighs, and chuckles embedded in an

interview session brought a greater sense of authenticity to the descriptions and conclusions made by the investigator in her analysis (Bricki & Green, 2007).

3.5.2 Transferability: thick description

Filed notes were taken by the investigator in the contexts in which the observed phenomena and events took place. These notes served to provide enough context so that a reader from outside the culture of the amaBomvana could make meaning and sense of the phenomena being described.

3.6 Data analysis

Data collected from the study was translated from isiXhosa to English by the investigator. Multiple methods of data analysis were utilized, including tables and qualitative narrative to describe the data.

Theme identification was utilized as one of the most fundamental tasks in this qualitative research. According to Whitehead, themes emerge from the characteristics of the phenomena being studied (Whitehead, 2004). All emerging themes from this research were subjected to analysis and these included emerging themes from the focus group discussions, from data from the healers on how they see the process of working together with health professionals in the area and vice versa. Each theme and subcategory were explored in depth and analysed through both the cultural and theoretical perspectives.

3.6.1 Describing themes emerging from the data:

The Social Inquiry (SI) technique was used to describe the themes that emerged from the data. This technique involves identifying the themes that characterize the experience of participants, such as identifying areas of social conflict and cultural contradictions (Bricki & Green, 2007). This method was inspired by the works of Bricki & Green, who in their training guide on qualitative research titled *A Guide to Qualitative Research Methodology (2007),* cite that this technique of theme identification is ideal because it allows the investigator to efficiently identify both formal and informal methods of social control used in the community being studied, procedures used in managing impersonal social relationships, means by which people acquire and maintain achieved and ascribed status, and information about how people solve problems (Bricki & Green, 2007). This technique proved to be particularly important in helping the investigator understand how the participants think about themselves, each other, their surrounding environments, events and relationships.

Additionally, the Compare and Contrast approach was used, which is a technique based on the idea that themes represent the ways in which texts are either similar or different from each other (Bricki & Green, 2007). This was achieved by comparing the responses of participants from different Focus Groups and villages to see in what ways their statements and ideas about indigenous medicine differed from each other. This technique helped the investigator compare research answers to questions across people, space, and time (Bricki & Green, 2007).

3.6.2 Analysing data according to study objectives

- **Study objective: Describing the indigenous healers of Madwaleni**

The objective of identifying the indigenous healers was met by organizing the type of healers and their specializations in a table, which will be further substantiated with data relating which communities in Madwaleni the healers work and reside. No actual personal names of the healers were presented in the data table. The data was presented in a two-way table format, which contained data on two characteristics (type of healer, specialization and illnesses managed). In such a table, therefore, the caption was divided into two co-ordinate parts. The data was also organized in a pie chart that showcases the distribution of indigenous healers that participated in the study by numbers. Charts that depict relationships between the indigenous healers were also used to present the data.

- **Study objective: Describe the illnesses these healers manage and what herbs are used to treat these illnesses**

The objective of linking the herbs to the illnesses was met by presenting the data in a manifold table which had more than two characteristics of data charted. This data table, though complex was chosen because it is ideal for representing this sort of data as it enables full information to be incorporated and helps facilitate analysis of all related facts (Bricki & Green, 2007). The data plotted included the indigenous names of the herbs, the illnesses they treat, dosage and methods of preparation. Still, as a normal practice, not more than four characteristics should be represented in one table to avoid confusion, therefore other related data analysis methods were used to show the remaining characteristics.

- **Study objective: Describe and catalogue the herbs (ethnobotanical diversity) used by these healers to treat each illness, and the precise ethnobotanical environments in which these herbs grow. Secondarily, describe the relationship the healers have with these environments.**

The indigenous herbs and their growth environments were documented photographically. The natural botanical environments that the herbs grow and the link between ethnobotany and the healers were described in a narrative analysis method where the texts were analysed within their social, cultural, and historical context from many different perspectives. As described in the Bricki & Green (2007) body of work, this technique is useful in qualitative research because it allows for the data to be deconstructed to reveal powerful discourses, hierarchies, presuppositions, deliberate omissions and polar opposites which were present in the data (Bricki & Green, 2007). The names of the plants, including their habitat and distribution as described in already published literature was integrated into the presentation of the catalogue. This was done to provide the reader with an in-depth exploration of some of the literature that has already been published on some of these plants. In cases where literature was not found for a particular plant, this is stated in the catalogue. These literature citations were include in the presentation of the catalogue, along with the reported local uses cited by the indigenous healers. This provided an opportunity for the reader to compare what has been published in literature with what is being done by the local people in Madwaleni in terms of the use of these plants. The analysis was based on large units of texts and biographical stories collected from the indigenous healers, and the moral and transformational dimensions of storytelling was explored.

Dissemination of results:

The investigator plans on disseminating the findings of this study in academic publication journals, seminars, meetings and conferences. How she plans to achieve this is by searching for journal calls and/or conference calls that suit each of the draft articles. Each article will be subjected to additions and revisions according to the criteria articulated by the journal or conference. The investigator has already identified possible academic journals that she anticipates to submit to as shown below, but she remains open to other possible journals that suit the articles.

As already mentioned in the introduction section of Chapter 1, this thesis presents an appendix section that includes 4 draft publications that will possibly be sent to the following journals:

1. *The Journal of Ethnopharmacolgy*

- Cataloguing the Indigenous Herbs of Madwaleni and the Ethnobotanical Environments in Which They Grow

2. *Indilinga: African Journal of Indigenous Knowledge Systems*

- The Indigenous Healers of Madwaleni and the Illnesses They Manage

3. *Journal of Primary Health Care and Family Medicine*

- The Relationship Between Indigenous Health Practitioners and Biomedical Practitioners in Madwaleni

4. *Agenda; Empowering Women for Gender Equity*

- The Journey of Becoming a Western Educated Female Indigenous Healer in Madwaleni

3.7 Application of ethics principles

Approval for the study was obtained from the Stellenbosch University Health Research Ethics Committee 1 (Ethics reference #: S17/05/101). The ethical principles of the Declaration of Helsinki, the South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research were adhered to. Issues of intellectual property, respect for persons and justice pertaining to the knowledge collected from this study were handled according to the guidelines offered by these policies which all condition that signed consent forms that clearly state the mutually agreed terms for the study need to be received before collecting any resources and knowledge from indigenous healers (Wynberg, 2004). In line with the Health Professionals Council of South Africa (HPCSA) *General Ethical Guidelines for Researchers* (2008), this study applied the three basic ethical principles throughout the investigation, namely best interest or well-being of participants, respect for persons and justice.

Best interest or well-being includes non-maleficence (minimizing harm) and beneficence (maximising benefit) (HPCSA, 2008). By interviewing indigenous healers the aim was to learn how to better support them in their endeavours and inspirations for improving health in their communities. It appeared that by granting the indigenous healers a space to reflect and to discuss made them feel listened to, and that their opinions are appreciated. One participant said that she felt emancipated by being listened to and understood through the process of expressing her perspectives. The investigator was committed to being respectful and accommodating to the experiences of participants in the manner in which she provided spaces of dialogue and discussion. There was minimal risk associated with being interviewed in this study, but the investigator kept in mind that some participants might feel uncomfortable retelling stories that caused them distress and trauma. For that reason, she remained alert and sensitive to the participants' needs and requests in any way that maximized their comfort.

Respect for persons includes autonomy (self-determination) and confidentiality (respecting privacy) (HPCSA, 2008). The investigator made sure that she included only participants that were above the age of 18 years and had health management experience, a combination of which reduced their

vulnerability. The investigator provided detailed information about what was required of participants in plain language and also in writing before participants signed the consent form and before they engaged in any discussions or interviews. The process of informed consent made clear that participants could withdraw from the study anytime they wished and that they would not be negatively affected by participating or choosing to withdraw from the study. To protect the participants' privacy, the investigator collected only personal information that was relevant to the discussions to provide context for the participants' responses, such as their gender and age. These personal details were not published in this study and only pseudonyms were used in places where the exact words given by the participants are cited. All data was kept locked in a safe cupboard in the researcher's office to ensure maximum security.

In terms of justice, the investigator ensured that she did not discriminate against any type of indigenous healer that wanted to participate in the study, granted that they were of legal age (18 years or older). Although there were healers who were younger than the age of 18 years, the investigator did not consent them to participate in this study. This was not done with the intention of discriminating against these younger healers, or for making them feel like their opinions and experiences are not valued because they are below the age of 18 years. Instead, the investigator explained to them that this was done because of ethical reasons as minors cannot legally consent for themselves without the approval of a parent or guardian (HPCSA, 2008). The investigator conducted all discussions and interviews in isiXhosa because all of the participants are native isiXhosa speakers. This was done to remain sensitive to the participants' cultural and language backgrounds. It was explained to participants that their responses would be translated into English by the investigator solely for the purpose of presenting this study, so that they did not feel like their native language was being undermined or misrepresented.

Intellectual property was protected by adhering to the Ethics Code assembled by the !Xun, Khwe and !Khomani indigenous people of the South African San Council. The code also describes how benefits from the research should be shared with the community, which is not limited to only money (Institute, 2017). For this study, the investigator did not pay the participants to partake in this study, but rather she assisted the indigenous healers to form their own coalition of indigenous healers, with the intention of the coalition being to organize healers into a group where they would have continuous spaces to discuss and develop collective solutions to the challenges faced by indigenous healers in the Madwaleni area and all its surrounding villages.

3.8 Limitations and challenges

Limiting factors that might have affected the data included the investigator's gender, age and profession.

- **Gender and age**

The amaBomvana are a patriarchal society, with women being expected to follow the laws of *ukuhlonipha*, which dictates how a woman is supposed to act, dress and move in spaces where men are present. The investigator tried her best to uphold and respect this cultural law, but with immense difficulty. As a non-Bomvana person who was not familiar with the culture because she did not grow up in it, the investigator might have made some slight errors in the manner in which she spoke, dressed and engaged in spaces where she was the youngest female person in the setting. The investigator acknowledges that some of these small mistakes might have affected how the participants perceived her and consequently might have affected the data.

- **Profession**

The investigator being a young, Western educated female scientist who spoke English proficiently might have resulted in a slight bias in the information given by participants, especially in issues regarding the intricate and sacred practices of indigenous medicine. This is because in Madwaleni the realms of formal Western education and biomedicine are spaces of discomfort for the indigenous people. The investigator is also an indigenous healer, and hence already came in with her own understandings and conclusions of the realm of indigenous medicine. This fact posed a challenge because as an investigator who is also an indigenous healer, the investigator's role in the research process was multi-dimensional because she was conducting research within an indigenous health system that she is a part of. Hence, the investigator being an indigenous healer herself made her inherently laden with biases which might have affected her analysis of the data.

3.9 Summary of the chapter

This chapter served to provide an understanding of the research methodologies, techniques and tools that were used in this study. Some of these methods were inspired by techniques that have already been used by other researchers in the field of qualitative research. However, the investigator also used indigenous methods of conducting research. A description of these techniques and how they served to meet the study objectives was given within context of this study. This chapter also provided an understanding of how these various tools and techniques were used to present the data from this study.

CHAPTER 4

PRESENTATION OF FINDINGS

4.1 Introduction

This chapter serves as the results chapter of this thesis. In this chapter, the data is presented in tables, figures and themes emerging from the study findings. Secondarily, this chapter is presented in sections accordingly in order to adequately address each of the study objectives.

The first section describes the various types of indigenous healers found in Madwaleni and their indigenous health management practices. This section serves to address the study objective of describing the indigenous healers of Madwaleni. Subsequently, the section gives an in-depth understanding of the various fields of indigenous medicine that exist in Madwaleni and how they operate.

The second section describes the illnesses managed by the various healers of Madwaleni, and subsequently how these illnesses are diagnosed and treated. This section meets the objective of describing the types of illnesses managed by indigenous healers in Madwaleni.

The third section details some of the herbs and plants that are used by the healers to manage these illnesses presented in the form of a catalogue. This catalogue meets the objective of describing and investigating the diversity of indigenous plants used to manage illness in Madwaleni and where these plants grow. This section also meets the objective of describing the relationships that exist between the indigenous healers of Madwaleni and the natural ethnobotanical environment and also presents the critical issues that are being faced by healers with regards to their relationship with these natural environments.

The fourth section showcases the themes and relationships that emerged from the study objective of describing the relationship between indigenous healers and biomedical professionals in Madwaleni. These themes are presented through presentation of key critical points emerging from the FGDs and interviews conducted with healers and biomedical professionals.

Also presented in this results chapter are two critical case studies that emerged from the findings of the study. These case studies serve to inform the reader about the many intersecting realities and phenomena observed by the investigator during the course of the study and offer a more in-depth analysis of the study objectives.

4.2 The various types of indigenous healers found in Madwaleni

The indigenous healers of Madwaleni can be categorized into 5 categories: (1) *amaGqirha* (indigenous doctors) (2) *amaXhwele* (herbalists), (3) amaTola (older elite men) (4) older elite women (5) *abaThandazeli* (Christian faith healers), who all operate within the folk arena. Below in table 1 are the various types of healers of Madwaleni who participated in this study and their specializations and skills they offer.

Table 1: Healers of Madwaleni and their specializations.

Category of healer	**Specialization**
AmaGqirha	• Divination • Consulting with ancestral spirits • Treatment of spiritual symptoms of illness • Conducting rituals and ceremonies
AmaXhwele	• Making herbal and animal based medicines • Treatment of physical symptoms of illness
AbaThandazeli	• Conducting Christian prayer to treat illness • Making of holy water
AmaTola	• Making herbal medicines • Treatment of physical symptoms of illness.
Older elite women	• Making herbal medicines to manage illness within the home situation • Treatment of minor health ailments

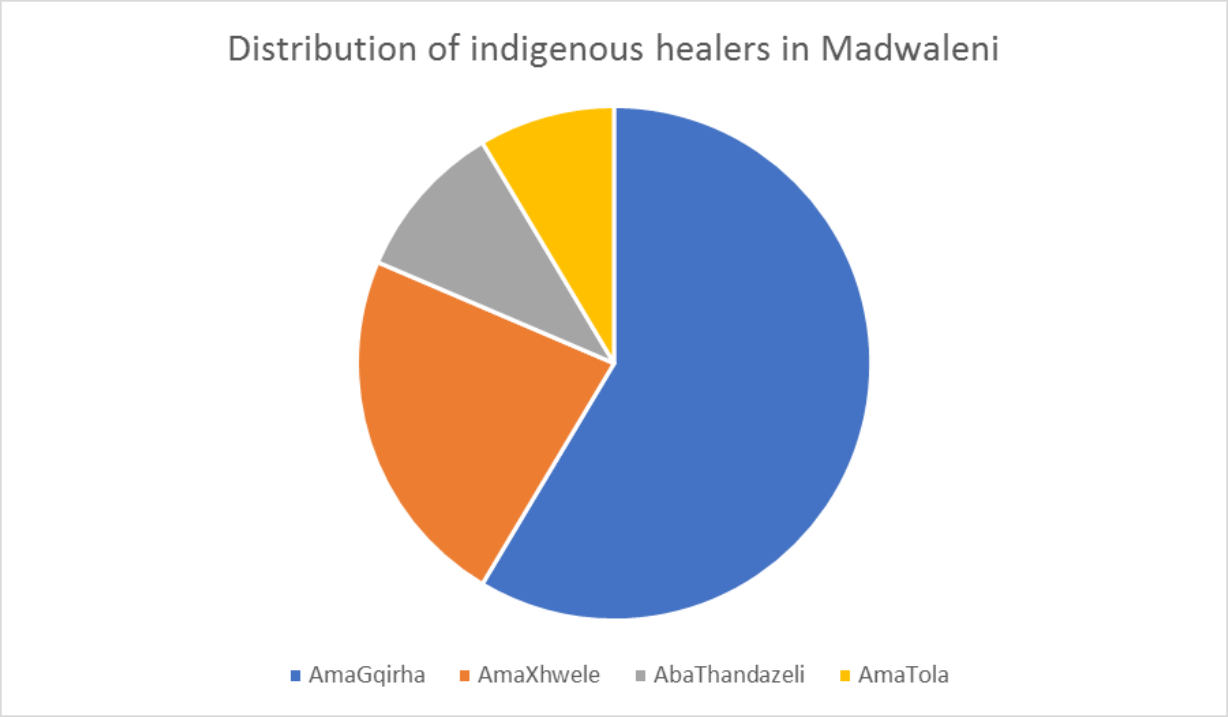


Figure 4: The indigenous healers of Madwaleni and their distribution. AmaGqirha (52%), AmaXhwele (20%), AbaThandazeli (16%), AmaTola (12%).

Figure 4 presents the distribution of the healers as they participated in this study. However, this does not mean that healers cannot function in all categories or a combination of these. There are some healers who are both indigenous doctors as well as being Christian faith healers, and there are older elite women who additionally practise as Christian faith healers and/or indigenous doctors.

In this study, the older elite women who participated were also practising as *amaGqirha* healers. These older women started off as *amaGqirha* who went through ukuthwasa, and because of their age and position in the families, they regard themselves as older elite women. This intersectionality is welcomed within the indigenous healing community of Madwaleni and partnerships are encouraged.

Intersectionality forms a crucial part of amaBomvana indigenous medical care and most indigenous healers practice a combination of the various indigenous healing strategies when it comes to managing illness. Hence, it is common to find a healer that is trained in more than one practice. The descriptions below showcase the various types of indigenous healers operating within Madwaleni and describes in detail their exact roles and practices within the community.

4.2.1 AmaGqirha

The *amaGqirha* are the most commonly occurring indigenous healers of the Madwaleni area recorded at 52% for this study. The exact number of *amaGqirha* operating in Madwaleni is uncertain as there are healers constantly moving in and out of the community either to come to receive training or to assist their colleagues in managing illness. The chart below depicts the organization and hierarchy of the realm of the *amaGqirha* of Madwaleni. Students graduate between year 4 and 6.

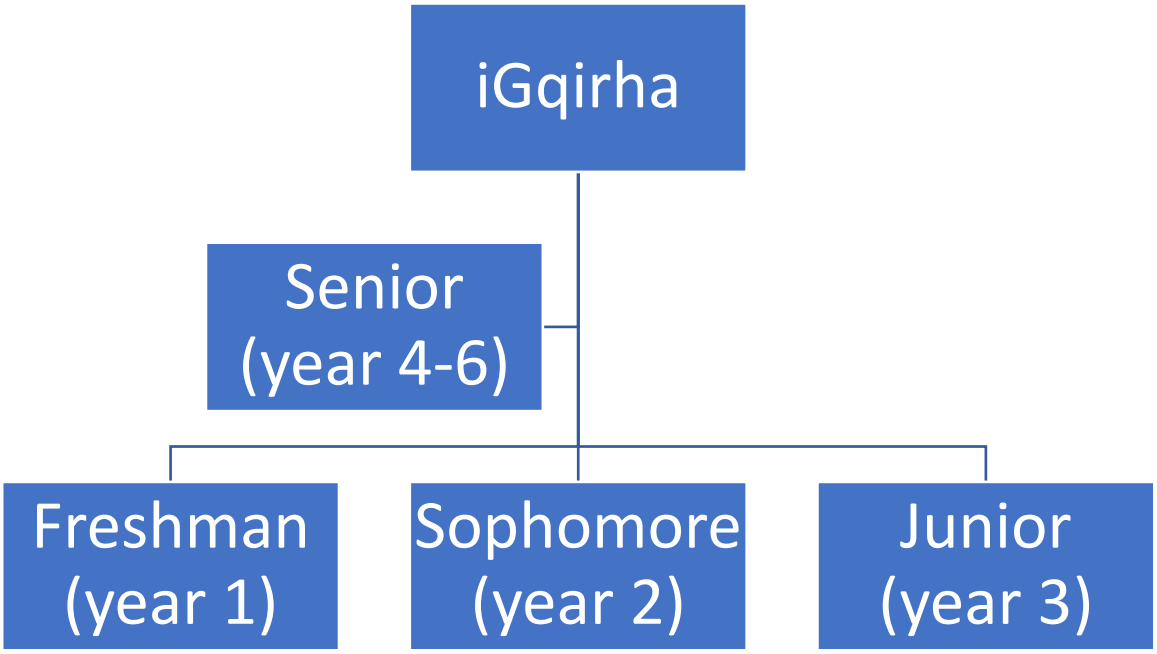


Figure 5: The organization and hierarchy of the realm of the *amaGqirha* of Madwaleni.

The realm of the *amaGqirha* of Madwaleni is organized as described in the chart above. The *iGqirha* (singular) is the teacher, the *thwasanas* are the students. In Madwaleni, the average training period to become a professional *iGqirha* is long, often lasting 6 years, although some healers can train for up to 10 years.

During this time, the trainee follows a rigid apprenticeship regimen under the supervision of their teacher. The student is required to move in with their teacher at the teacher's home, which serves as the academic institution, until they graduate. The total number of these training institutions in Madwaleni is unclear and was not estimated for this study. The structure of the training is as follows:

The stages of training to be an indigenous healer in Madwaleni:

The training to become a healer is highly sacred and is performed under strict rules and regulations. The diagram below showcases the four main stages of training to become an *iGqirha* healer. The

community structure of the amaBomvana in Madwaleni is family orientated and places a strong emphasis on communal relationships. However, hermitry is a big part of the training protocol of the *amaGqirha* in this area. The student is required to spend time secluded from society (including from family, relatives and friends) by undergoing a series of vision quests at the river, the ocean and the forest as part of their schooling.

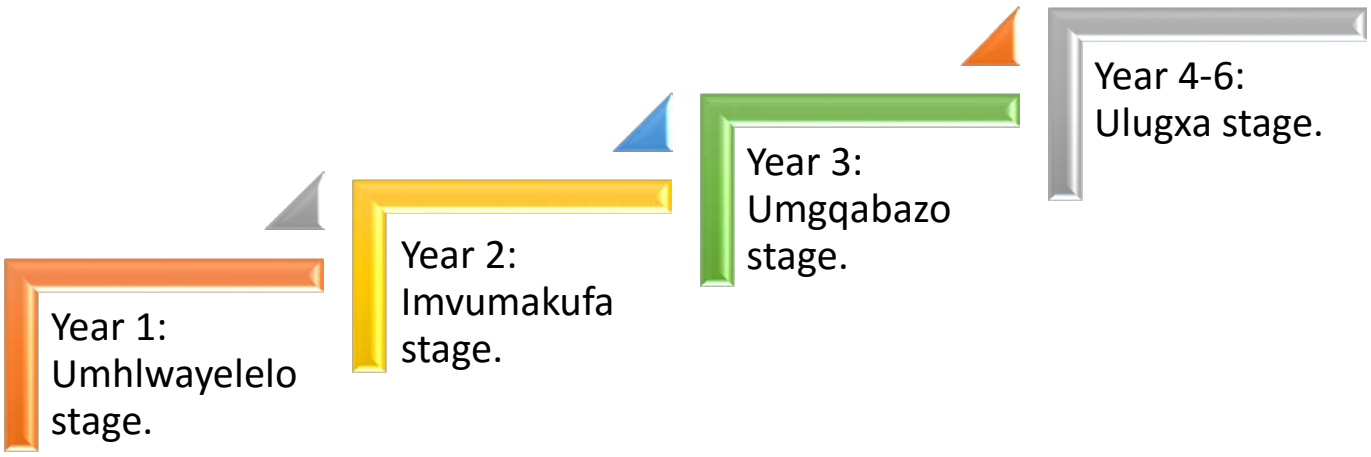


Figure 6: The stages of training to become an indigenous doctor in Madwaleni known as *Ukuthwasa*.

- Year 1: The student is initiated into their first year of training and is given a new name as a sign of a new beginning. In addition to this, the student is expected to be chaste throughout their training period, to follow a strict diet that excludes milk, eggs, beans, coffee, alcohol and liver.
- Year 2: The student partakes in his/her first animal sacrifice ritual to the ancestors as a test of their ability to communicate with the ancestral spirits.
- Year 3: Throughout this period, the student is secluded from other people for a number of days to be in the forest and the river, with the intention that by doing so, the ancestral spirits will draw closer to the student to teach him/her about the intricacies of indigenous medicine.
- Year 4-6: Diet restrictions are lifted once the student reaches their final year of training. At this stage, the student is able to work without supervision, is able to assist the teacher in the training of the other students, and is considered ready for graduation.

However, some teachers are more lenient in terms of the enforcement of these rules. Although all the healers who participated in this study expressed their support of these rules and restrictions, it did emerge that there is variation in the manner in which each teacher trains his/her students. Unfortunately, there is no regulation system currently in place in Madwaleni that keeps track of who adheres to or violates the rules of the *ukuthwasa* process in terms of the training of *amaGqirha*.

4.2.2 AmaXhwele

The *amaXhwele* healers of Madwaleni operate as herbalists and are generally not recruited by the ancestors but do undergo an extensive training regimen in the form of an apprenticeship under the guidance of an established herbalist. The *amaXhwele* have an extensive knowledge of plant and animal medicinal products and are revered for their knowledge of cultural medicine known as *amayeza*. These healers do not diagnose spiritual illness as these are considered the realm of the *amaGqirha* who communicate with spiritual forces. The role of the *amaXhwele* is to provide herbal medicines to treat physical symptoms of illnesses. If the herbalist suspects that there is a spiritual element to the patient's illness, such as an ancestral element, then he will refer the patient to an *iGqirha* for divination. In Madwaleni, generally the patient first consults with an *iGqirha* healer to receive a diagnosis and cause of illness. If the *iGqirha* is unable to provide the medicine needed to treat that illness, then the patient will be referred to an *iXhwele* (singular) for collection of those medicines. Patients move between both categories of healers as depicted. Figure 4 below presents the relationship between the *amaGqirha* and *amaXhwele* healers of Madwaleni.

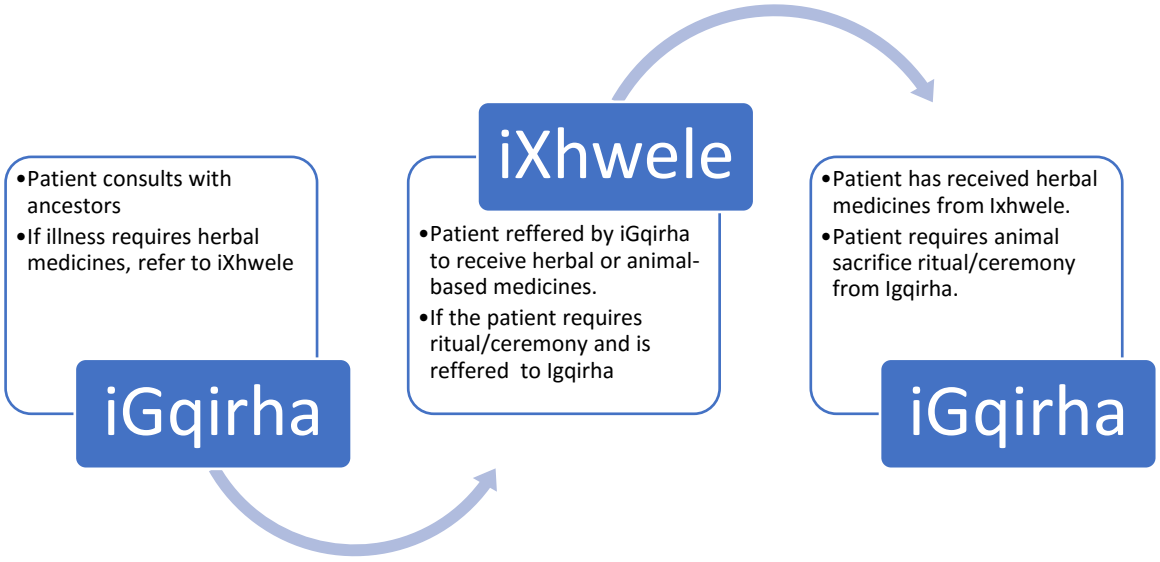


Figure 7: The relationship between the *amaGqirha* and *amaXhwele* healers of Madwaleni.

As the diagram above indicates, intersectionality exists between the *amaGqirha* and the *amaXhwele* healers. In Madwaleni, the majority of *amaXhwele* are men. Women rarely take up the practice as it is traditionally believed that women are too sensitive to handle some of the grisly tasks an *iXhwele* has to perform in order to make certain medicines. Some of the IHK strategies the *amaXhwele* utilize involve working with animal body parts, which is believed to be more suitable for males and not for females. Some of the *amaXhwele* healers also perform exorcism, which has been described as an incredibly frightening process that requires a lot of stamina and valour, which women are believed to lack. Some of these perceptions about the ability of women to handle gruesome tasks are shaped by the patriarchal culture of the amaBomvana in which the *amaXhwele* operate.

4.2.3 AmaTola

The *amaTola* healers of Madwaleni are a group of male healers who have an innate knowledge of medicine and healing, which is believed to be passed down from generation to generation. The *amaTola* acquire their knowledge through dreams and visions from their ancestors, who were also *amaTola* when they were alive. However, despite the apparent spiritual aspect of being an *iTola* (singular), the *amaTola* do not undergo *ukuthwasa*, or any other custom of formal cultural training under a teacher. It is believed that the ancestors teach the *iTola* through dreams and visions. The process of healing and training for the *iTola* appear to be continuous and constant as *iTola* receives a vision and makes medicine, once the task has been completed, the next vision will be of another herb. Below in figure 8 is the process of healing and training for *iTola.*

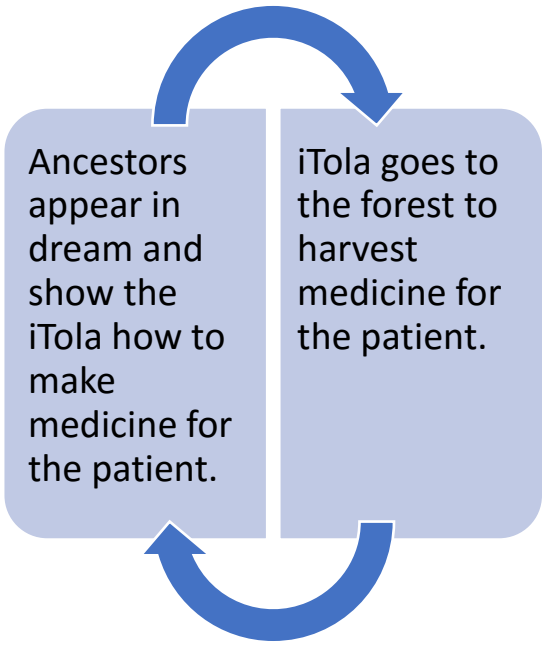


Figure 8: The process of healing and training for the *amaTola*.

The *iTola* receives a vision and makes medicine, once the task has been completed, the next vision will be of another herb. The process continues as so. The *amaTola* generally harvest their herbs and animal based remedies from the forest at night time, although they can also harvest during the day. It is believed that the ancestors reveal the position of an herb during the night when the *iTola* is asleep. The *iTola* has to immediately get up and go to the forest to collect that herb. Although there is similarity between the *amaTola* and the *amaGqirha* in terms of the spiritual vocation from the ancestors, the manner in which the ancestral calling is answered differs significantly. For one, the *amaTola* do not undergo spiritual initiation like the *amaGqirha* do. An *iTola* starts learning about IKS from an early age and usually grows up acquiring knowledge throughout their childhood and into adulthood through the process of dreaming and harvesting herbs. There are no female *amaTola* healers in Madwaleni, reason for this being the belief that only men can physically and emotionally cope with the experience of having to travel alone to the forest at night to harvest medicine.

4.2.4 Older elite women

Mji's study on the role of elite Xhosa women in the Eastern Cape Province revealed that older Xhosa women use indigenous health knowledge (IHK) for the management of health problems in their home situation and that both minor and major health ailments are managed in the home (Mji, 2013). In the Mji study, an extensive description of the illnesses managed by older elite Xhosa women is given (see appendix B). Additionally, these women act as family counsellors, custodians of IHK and mentors for younger women. The older elite women of Madwaleni utilize a variety of strategies to manage illness. They make use of herbs and plants that grow naturally around the home or in the garden. The illnesses they manage are mostly women-related illness, such as child birth, pregnancy and post-partum support. They also manage common minor health ailments within the family unit. They also share their home-based remedies with other older elite women and other groups of indigenous health practitioners. This group of healers was not investigated much in this study since the Mji (2013) study has already explored and detailed these healers in depth. For this study, the four (4) elite women that participated were also practising as *amaGqirha* healers.

4.2.5 Abathandazeli

Christianity is the most common Western religious faith amongst the amaBomvana of Madwaleni and most people prefer to practice Christianity alongside indigenous amaBomvava religious beliefs. However, very few Christian churches allow for such intersectionality to take place as it is seen as sinful and unchristian to practice indigenous faith within the church. Hence, most devout Christians in Madwaleni do not practice indigenous religion. There are various church groups found in Madwaleni,

such as the Catholics, Anglicans, Lutherans and Pentecostal. Apart from being a place of worship, the church also provides health care with various churches having their own unique ways of health management practice. It is believed that the vocation to become a Christian healer comes from God and one is born with those gifts innately. Those members of the congregation that provide health care are referred to as “abathandazeli” meaning “faith healers”. The St. John’s Church located near the hospital, in the village of Manganyela, is the church with the most faith healers in Madwaleni as it seems like it is the church of choice for people with these spiritual gifts. There are other St John’s churches located near Xorha and Nkanya as well. The faith healers do not use indigenous herbs and plants in their practice, instead they use holy water and other Christian relics such as the cross, candles and Christian rosaries. The faith healers treat mainly minor ailments which are usually not treated with herbs but with either consumption of holy water or prayer, or a combination of both.

4.3 The illnesses managed by indigenous healers in Madwaleni

The table and descriptions below showcase the various types of illnesses managed by the indigenous healers of Madwaleni. Intersectionality forms a crucial part of amaBomvana indigenous medical care and most healers practice a combination of the various indigenous healing strategies when it comes to managing illness.

As can be noted, some illnesses that are managed by the indigenous healers of Madwaleni are not physical illnesses, but rather are spiritual, financial and/or emotional situations that are culturally interpreted as "illness". This is because the cultural understanding of illness amongst the amaBomvana people stretches much wider than the biomedical definition, and takes into consideration the social and spiritual experiences of the individual. Being unable to get married or get employment is considered illness, just like having a headache or leg pain is defined as illness. This definition of illness goes even broader to include experiences and afflictions that are associated with magic or superstition, such as witchcraft hexes and evil spells.

The actions of witchcraft are considered real sickness amongst the amaBomvana and medicines are administered to treat these afflictions, and the various healers have their own strategies that they use to combat witchcraft. Additionally, the *amaGqirha* healers consider the training of students as an illness because of the psychological affliction associated with the *intwaso* phenomenon by which one is believed to be called by the ancestors. The student is treated as a patient throughout their training and is given medicines to treat the *intwaso*. Below in table 2 are the illnesses managed by the various indigenous healers of Madwaleni, showcasing specialization by each field. The illnesses are shown in the local language, and an attempt is made to give an English translation of the terms. Brief descriptions of the diagnosis and treatment methods of each illness are also given below in Table 2, showcasing specialization by each field and brief descriptions of the diagnosis and treatment methods of each illness.

Table 2: The illnesses managed by the various indigenous healers of Madwaleni.

CATEGORY OF HEALER	ILLNESSES MANAGED	TRANSLATION	SYMPTOMS AND DIAGNOSIS
iGqirha	1. Umntu oxhuzulayo 2. Ukwendisa iintombi ezingandiyo ndiyazihlamba 3. Ukuphehlelela ebantwini abanomsholovu 4. Ukusebenzisa umoya 5. Ndiyaqeshisa ebantwini abangasebenziyo ndibahlamba ngeyeza 6. Umntu onedropu 7. IIntwala zehagu namaqotwana	1. Seizures 2. Marriage for unwedded maidens 3. Training of indigenous healers 4. Prophecy 5. Employment for job seekers through ritual cleansing 6. Drop (an illness characterized by genital bleeding) 7. Genital lice (crabs) 8. Vertigo 9. Vomiting blood 10. Anger issues	1. Uncontrollable shaking of the body due to evil spirits dwelling inside the patient's body inflicted via witchcraft. 2. Diagnosis performed in consultation with the maiden's ancestors to figure out reasons for not finding a spouse. Common diagnosis given for the maiden not being able to find marriage is cited as jealousy inflicted in the form of witchcraft from family members or from community members. 3. Diagnosis performed in consultation with the potential trainee's ancestors to reveal whether or not the trainee is being called. Once confirmation is given by the ancestors, the student begins training. 4. Someone who has potential gift for prophecy (seeing visions about other people's lives) receives confirmation from the iGqirha through consultation with that person's ancestors. 5. Those who are unable to find employment are treated with a special mixture of herbs to lift darkness and to bring luck. 6. Drop is characterized by genital pain and bleeding from the penis. Herbal remedies are given to treat this. 7. Itching in genital area, small bugs in pubic hair. Diagnosis is that the illness is caused by witchcraft from jealous ex-lovers. 8. Uncontrollable dizziness that is treated with herbal concoctions.

	8. Umntu onesiyezi nesibhobe esiphakathi kwamagxa 9. Umntu okupha igazi 10. Umntu onengqekula		9. The patient is diagnosed by consulting the ancestors to figure out cause of vomiting blood. A diet of low fat foods is often suggested to combat nausea. Herbal remedies are also ingested. 10. Anger is diagnosed as a sickness caused by ancestral unrest within the family unit. A goat sacrifice to appease the ancestors at the patient's home is often recommended as treatment. The goat sacrifice is performed by a trained iGqirha. A necklace called "intambo yokulunga" (necklace of goodness) is made from the goat skin and hairs and is worn by the patient as a form of long term treatment of the anger issues.
iXhwele	1. Ukungafumani mntana 2. Intloko 3. Uvalo 4. Idliso 5. Umkhondo 6. Umntu oligeza 7. Ibekelo 8. Umntu obona abantu 9. Isinqa nomlenze 10. Ukuqinisa umzi	1. Infertility issues 2. Headaches 3. Anxiety 4. Stomach hexes 5. Evil spell caused by evil snakes 6. Mental health 7. Hexe stepped on which causes painful legs 8. Hallucinations 9. Waist and leg pain	1. Infertility is considered to be caused by witchcraft. The ixhwele uses a combination of plants; *mathamabini* applied to vaginal area, *uvala mazubuko* for steaming, *isindiyandiya* to dispel the witchcraft. 2. Headaches are treated with *ugwada*, which is an indigenous nasal decongestant in the form of a fine powder. 3. Anxiety is treated by burning *impepho* as incense, and ingesting boiled marijuana as a purgative. 4. Herbal remedy and strength for treating stomach hexes depends on severity of illness. Most common plant used is *isihlungu.* 5. Evil snakes are witchcraft familiars that are believed to be sent by witches to constrict and harm both the people and animals of the household. A combination of *intelezi* plants are used to ward off the snake.

	11. Ukususa iintlanga	10. Strengthening of the home using magic 11. Removal of hexes	6. Various purgatives are used to treat mental health related illnesses. Only illnesses considered to be the result of witchcraft are treated by the iXhwele. Mental afflictions associated with an ancestral calling are treated by the amaGqirha. *Intelezi* is often used, the most common being the *umatyumtyumane* plant. 7. The diagnosis for evil hexes is made by an iGqirha healer who consults with the ancestors to figure out the cause of the painful leg. The iXhwele treats the pain using herbs to combat witchcraft, some include *isindiyandiya*, *umgwenye* and *umbomvana*. 8. Hallucinations are considered witchcraft when the person wishes to physically harm others or is claiming to "see" people who wish to harm him/her. These are treated with enemas, purgatives and bathing agents. 9. Same diagnosis as "ibekelo". 10. The iXhwele differentiates his power from other amaXhwele through the ability to strengthen the home (meaning to use plants and animal products intended to ward off evil spirits, witches and misfortune). This recipe is kept secret and the procedure is only performed at night. 11. The iGqirha healer makes the diagnosis as to the causation of the illness and refers patient to an iXhwele. The iXhwele makes a remedy depending on the diagnosis.
iTola	1. Inqekula (a lethal illness)	1. Lethal illness called "ingekula"	1. Symptoms include weight loss, seizures and shaky hands. Treated with *magageni*, a very potent purgative.

	2. Umkhamelo ngeyeza 3. Ukuxhuzula 4. Umeqo 5. Intloko ephambanisayo 6. Ukuqinisa komntu oguliswa ngumoya omdaka 7. Ukubethelela umzi 8. Isibaji sabantwana bangangenwa ngumoya omdaka 9. Iintwala zehagu 10. Umgqwaliso 11. Isiphondo sabantu abafuna umsebenzi	2. Cleansing of the blood through use of potions and concoctions 3. Seizures 4. Removal of evil hexes 5. Headaches that cause hallucinations 6. Protection against evil spirits 7. Strengthening and protection of the home through use of spells 8. Protection of babies from evil spirits 9. Genital lice 10. Removal of hexes and enchantments	2. *Umkhamelo* is a recipe consisting of various blood purifiers including *ingcwelane* (aloe). Various symptoms may require treatment with *umkhamelo*, such as painful joints, seizures and swollen vaginal area after rape. 3. Seizures are treated with *umkhamelo* recipes that are both ingested and used as enema. 4. The amaXhwele and amaTola are renowned for making *amakhubalo* (protective amulets) to protect from evil hexes. These amulets which are most commonly necklaces and bracelets are made of both plant and animal products. The most common amulet is called “ibhanti” (belt) and is worn around the waist permanently and is never taken off. 5. Headaches are treated with *ugwada* to relieve immediate pain, and a combination of purgatives and bathing agents are used to remove the evil spell that is believed to be causing the hallucinations. 6. See point 4 above 7. *Amakhubalo* are made for the patient as stated in **4 above** 8. Special amulets are made for a baby once it is born. The amulet is worn around the baby’s waist. During pregnancy, the mother is given an oral concoction called *umchamo wemfene* (pee of a gorilla) which is believed to boost the mother’s protection against any evil spirits. This concoction is plant based despite the peculiar name. 9. Genital lice are believed to be the cause of witchcraft known as “umeqo” caused by the jealousy of ex-lovers. Treatment includes bathing agents and purgatives to remove the evil spell.

	okanye ukunyuselwa ubekwisikhundla esiphezulu	11. Charms for finding employment or for getting promotions at work	10. Enchantments are known as “idliso/umgqwaliso” and are believed to be used by an envious lover to trap a man/woman in a relationship through ingestion of poisoned food. Diagnosis is made by an iGqirha in consultation with the ancestors. The iTola makes a purgative to remove the poison. 11. Unemployment is considered a form of misfortune caused by evil spirits. Plants such as *intelezi* are used as bathing agents the remove the bad spirits from the unemployed person.
umThandazeli	1. Intloko 2. Ukukhusela kuSathana 3. Umbilini 4. Isifuba 5. Isisu 6. Imilenze	1. Headaches 2. Protection against Satan and demons 3. Anxiety 4. Asthma 5. Stomach problems 12. Leg pain	1. The abaThandazeli do not make use of indigenous amaBomvana herbs in their practices. Instead, they make use of Christian prayer, rosaries and holy water. All illness is believed to be unholy and the result of the works of Satan. A “Christian” purgative made of black tea, salt and holy water is used to remove evil spells that dwell within the body that cause illness.
older elite woman	1. Ngumeqo 2. Isiluma 3. Isisu somrhorho 4. Intloko ebuhlungu 5. Isisu seqabaga 6. Umlenze obuhlungu	1. Removal of evil hexes 2. Menstrual cramps 3. Runny stomach 4. Headaches 5. Other stomach issues 6. Leg pain	1. Umeqo symptoms include swollen and painful legs, ankles and knees. It is treated with *itolofiya* (prickle pear) thorns which are roasted over medium heat, cooled and then grinded into a fine powder and mixed with 250mL of lukewarm chicken gravy. 2. Menstrual cramps and labour pains are treated with the same remedy known as *uskholokota*. The roots are grinded and mixed in 250mL of cold water. 3. Runny stomachs in children are treated with an aloe known as *nomaweni*. The aloe is ground to a paste and mixed in 1L of cold water. The child

			takes 2 spoonful three times a day until symptoms recede. Adults are commonly treated with *isihlungu*, which is prepared in the same way. 4. Headaches are treated with *igwada*, which is an indigenous nasal decongestant in the form of a fine powder. 5. Other stomach issues such as cramps are treated with *isihlungu* or *mnonono* plants that are ground into a powder, mixed with 250mL cold water and drank immediately. 6. Leg pain which is not associated with witchcraft but with old age is treated with the *umhlabelo* plant. The roots are roasted, grinded into a powder and mixed with 250mL of cold milk. This remedy is taken once a week to relieve stiff joints that cause painful legs in the elderly.

4.3.1 A description of the relationships between the indigenous healers of Madwaleni

As described in the section above, the indigenous healers of Madwaleni use various methods to manage illness in their communities, and intersectionality is welcomed. However, there are points of conflict between the healers, with some healers claiming superiority over other types of healers based on the rigorousness of the various training processes used in Madwaleni to train indigenous healers. Although communication between healers is welcomed, it comes with many challenges. A clear example is the strained relationship between the *amaTola* and the *amaGqirha*, with the former feeling that the latter treats them as less spiritually inclined because the *amaTola* do not undergo the ukuthwasa training process. However, even amongst the *amaGqira* who have undergone ukuthwasa, there are still communication challenges within that group, with some *amaGqirha* claiming to be better knowledgeable than other *amaGqirha*, causing rifts in their professional relationships. These issues are highlighted in the themes presented below that emerged during focus group discussions and in-depth interviews of indigenous healers of Madwaleni. All names presented here are pseudonyms.

4.3.1.1 THEME 1: The indigenous healers themselves have strained relationships

This theme heading is taken from a transcript of an interview with an elderly indigenous healer named Tata Rhadebe from Qatywa village in the Nkanya area. Rhadebe is an indigenous healer known as an itola (older elite men) and has taken training courses in biomedical diseases such as TB, HIV and diabetes. In this interview, Rhadebe expressed his experiences with being shunned by other healers because they do not understand his vocation. Amongst the healers of Madwaleni, there exists internal conflict as some groups of healers view themselves as being superior to other healers based on the type of training they have received and the nature of their spiritual calling.

4.3.1.1.1 SUB-THEME 1.1: Claiming superiority over one another

The importance of self-representation was an important factor identified by Rhadebe in his description of why the current relationship between healers is strained in Madwaleni. He reflected:

> *Amongst us as healers, some people don't want to be lead. What causes that is that some healers don't know exactly what being in a unified group means. When we try to get together to discuss issues, some healers bring their personal issues into the matter, and people end up fighting personal battles rather than focusing on the upliftment of the whole group and on discussing a patient's health.*

According to Rhadebe, the relationship between the amaTola healers and the amaGqirha healers is strained because the amaGqirha see themselves as being more spiritual because they are called to *ukuthwasa* and the amaTola healers are generally not:

> *My story is complex. I started using amayeza from a very early age. Even when I was still very much involved in the church, I still used amayeza although I did not thwasa. As I grew up, my gift got stronger. I would eventually start to have visions of amayeza from my ancestors. I would harvest them and use them as instructed in my vision.*

He further detailed how the ancestors even specifically teach him how to make medicine from these plants and herbs:

> *If there is a sick person coming my way, I would go harvest the herb and prepare it even before the patient arrives. The ancestors would tell me that a patient is coming with a particular illness and what herb I must go harvest. I harvest at night but I am directed to the herb even though it is dark.*

Tata Rhadebe stated that although his process would not count as ukuthwasa, he still experienced a very deep spiritual connection to his ancestors:

> *As my gift started to get stronger, it became difficult for me to keep a job. I struggled finding employment. I eventually decided to go back to school to get more qualifications, after that I got some jobs because I was a proactive person, I would get hired for random jobs. However, when it came to me getting paid, people somehow never wanted to pay me. After struggling, I eventually decided to give up on the whole job thing. After I made that decision, then my visions about amayeza got much stronger. I started to see the actual patients myself. I would see their sickness, and then I would see the iyeza I am supposed to use. When I woke up, I got a phone call from my family telling me that there is a person waiting for me at the homestead and I must immediately come home. That's when I decided to accept the gift. I harvested some ityantyisi beads and made a necklace and wore it. After accepting my gift, I was able to get jobs again.*

When the investigator asked how this difference in spiritual calling has affected his relationship with the amaGqirha, who have also detailed similar stories, he said:

> *To answer your question, I fall into the category of amaTola because I did not undergo ukuthwasa. I just have a gift from my ancestors. There is nothing I cannot heal. In fact when I am with the amaGqirha, I can get along with them because they do not see me as an equal because I did not formally train like they did. I get along with the amaXhwele much better because they too didn't undergo ukuthwasa but are still powerful healers.*

and he further explained how he gets along better with the amaXhwele rather than the amaGqirha:

> *The amaTola and the amaXhwele get along much better here in Madwaleni although we practice differently. An iXhwele learns amayeza from a teacher. We call that process of training ukuthwala because you are learning someone else's craft. The amaTola do not attend any apprenticeship under a teacher. They receive knowledge directly from the ancestors.*

This investigation revealed that the conflict doesn't just exist between the amaTola and the amaGqirha healers only, but also within the school of the amaGqirha itself there exists internal conflicts.

4.3.1.1.2 SUB-THEME 1.2: Internal competition strains relationships amongst the healers

In FGD4, indigenous healer Mama Manyawuza of Manganyela village gave her views on the matter by detailing a negative experience she endured within the school of amaGqirha. She said:

> *I once attended an intlombe near Xorha with Mama Ntlabathi. The healers from Manganyela hired a van and we attended the ceremony in big numbers. The iGqirha who was hosting the intlombe was very rude to us, and we could tell that she thought she was better than us because she could read and write. I could tell she wanted to mistreat us but we outnumbered her.*

She went on to further detail the reasons why the conflict between the healers in the *intlombe* started and said:

> *In her attempts to undermine us, she told us that we have no right to come from our village in such large numbers to come heal in a community that is not ours without any permits that prove we are really trained healers. She said that she herself has documentation and so do most healers in Xorha and that she has a right to ask us for documentation because this is her community and her people. She said if we don't have permits, we must leave. It became clear that she was trying to say that without any proof that we are healers, she cannot trust us. She got up and said that she has a right to tell us to leave the ceremony if we cannot produce these documents.*

She further mentioned that the in-fighting between the amaGqirha healers has the potential to negatively affect the health of patients because the conflict upsets the ancestral spirits. She explained that:

> *Our intentions were that the ceremony should be a success. We did not want to disturb the space with fighting. When conducting a ceremony, the fighting must not start between us*

> *healers. We have been hired to perform a service after all. We went there to heal. We must not now be the first people to cause trouble. If trouble starts, then it's only right that it be from the hosting family not us. This way if anything goes wrong, we know we are not to blame. When conducting a sacred ceremony, conflict is not good. The ancestors can get very upset and not allow the healing to take place. It is important that we as the healers remain humble even if someone tries to provoke you. I had the words to give her in return, but I didn't because I wanted to respect the space so that the family we went to heal can receive their healing.*

Although Mama Manyawuza did express concern over the words that were used by the other healer towards them, she still showed a sense of doubt about their not having permits. She mentioned that now that she has thought about it, perhaps having permits will reduce the infighting amongst the healers:

> *What I wish to see happen is that all of us as healers can be successful. Even if not all of us become successful equally that is fine because we cannot all be good at everything. But whatever you can do, I wish you can get a certificate that proves that you can do what you claim you can do.*

Her reasoning behind these comments was that if the healers of Madwaleni could be categorized by their specialization and given permits according to their specialization, then that would reduce the level of competition for business. Another healer from the same village of Manganyela who participated in the discussion shared the same sentiment and added that:

> *Yes I agree. Even if you only know how to make ugwada (a nasal decongestant that treats headaches), you must have a certificate that shows that you specialize in making ugwada. People will then know that it is the gift your ancestors gave you.*

Some of the points of conflict between the healers seem to be rooted in the competition for recognition. As one of the healers from Hobeni village, Mama Nosinoti, revealed in FGD6, there is competition about which healers are invited to social events to represent the group of indigenous healers of Madwaleni. Since its opening in 2006, the Donald Woods Foundation regularly hosts community health events and celebrations in honour of the community of Madwaleni. Some indigenous healers are invited to these events while some are not. This creates an energy of resentment between the healers as some feel rejected. Healer Mama Nosinoti expressed her concerns about this and said:

> *There are issues of competition between us as healers and it is affecting all of us. When there are meetings to be held at the Donald Woods Foundation and they ask for the presence of*

> *healers, they only invite a few of us. They send invitations to specific people. So you find that when it is time to enter the premises, we cannot all go in. They say they want only the ones that received invitations because they have a limited number of food packages prepared. At the gate they ask you for your name, if it is not written in their book, you do not attend the event. Some of us feel undermined by this.*

She further went on to add that some healers do not want to attend FGDs held at the DWF for this study because there is an underlying mistrust of one another:

> *Even now, many healers did not come to this meeting today because we have this thing of not trusting each other.*

She revealed that she fears that some healers want only themselves to be recognized and invited to special events. This level of competition between the indigenous healers has become toxic in the sense that it has resulted in a lot of mistrust and contempt amongst the indigenous healers themselves. These spaces of conflict need to be revisited as to allow for them to be reconciled. The investigator gives a detailed reconciliation model based on these critical incidences. The model is presented in the final chapter of this thesis.

4.3.2 A CASE STUDY EMERGING FROM THE STUDY

A part of the presentation of findings, this chapter will showcase two case studies that emerged from the findings of the study. These phenomena were observed by the investigator and were analysed using the technique of critical reflection.

The first case study showcases how the relationship between alcohol and ethical misconduct has been plaguing the realm of indigenous healers in Madwaleni. A lot of these issues have gone unattended and they continue to cause conflict.

4.3.2.1 Case Study 1: Abuse, alcoholism and ethical misconduct within the indigenous healing practice in Madwaleni

Violence against women is a pandemic that has been plaguing the indigenous healing practice in Madwaleni for many generations and it is also an unspoken occurrence. Because of the secretive nature of indigenous medicine, even the most horrific practices within this sacred school of thought have gone unheeded. Moult states that culture cannot be viewed as either all good or all bad, but rather traditions and practices within a culture change according to the area where people live and across time (Moult, 2003). Across many patriarchal cultures around the world such as that of the amaBomvana, certain traditions have been developed by men and emphasize male rights at the

expense of women. As a result, there are “many aspects of culture and tradition which are oppressive and harmful to women” (Moult, 2003). Part of my research work involved engaging with indigenous healers of this area in uncovering some of the issues that they face and in what ways the introduction of biomedicine has changed the medical landscape in the area. As part of my data collection methodology, I had to partake in gatherings often held in the healers’ homes. On one such occasion, I was visiting a healer’s home not very far from where I stay. She hosted the event in her *indumba*; an ancestral room where her ancestors reside and consult patients. It was an honour to be invited into her sacred space.

We proceeded with the welcome ritual in which she embodies her ancestral spirits and offers each person present a sip from her ancestral glass of libation. The next part in the prayer process was ritual dancing known as *umxhentso;* a dance performed to invoke the ancestral spirits and to invite them forth to join the prayer. As we were dancing in a circle, one of the male healers, who was also the hostess’s brother in law, jumped on top of me. I fell to the ground and cut my hand on a piece of broken glass. I told the hostess I was now ready to leave and she offered to walk me home. Her brother in law followed us, throughout the 20-minute walk home, he was harassing me, pestering me and pulling my arms and hand. It took me a couple of days to process what happened and to get to a place of calmness. I started to wonder, why is it that male healers are not taken into account for their abusive actions towards female healers? Why has it become normal for females to be mistreated in the indigenous healing practice? The following week, I decided to host a focus group meeting with all the female healers that were present that day. I wanted to figure out why they didn’t come to my defence when that man attacked me. What were they afraid of? As it turns out, he had violated some of the women in that room as well in the past. So, their refusal to come to my aid was due to the fact that they never settled the trauma that happened to them, and quite honestly I think they didn’t know how to respond. How does one deal with spiritual incest? It’s a deeper, more profound trauma because it’s both physical and spiritual. A violation against your physical and spiritual bodies is a complex ordeal to unravel and to reconcile. All sexual violence towards women is spiritual violation, no doubt about that. But what happens when you are a spiritual healer and you get broken in this way? How do you begin to heal yourself and your ancestors? How do you achieve your justice?

Our conversation went deeper into the psychological imprint that patriarchy leaves on females. I asked the lady who had hosted the *intlombe* to weigh in on why she allowed her brother in law to offend her and me in her home. She shared with me that she has also been victimized by her brother in law in the past. She reported the incident to her family told them of the events that occurred and who the perpetrator was. Her uncles decided it was best to consult with her brother in law’s family to lay a formal complaint. The two families met soon after, and the male elders decided that the best retribution would be a cow. So, her brother in law was ordered to pay her a cow as an apology. The cow had to be specifically female because it was being paid as compensation for a wrongdoing

against a female. The two families continued coexisting and so did they. He was then allowed to enter her home again and fulfil his duties as the brother in law, which often meant residing over family ceremonies held at her house, with her as a female member of the family having to serve him. I asked her if after all this had happened and the remuneration was paid, if she felt she had received justice. She didn't quite understand what I meant by the term "female justice". It's a term that has never made sense to her because she had never seen it in action in any stage of her life. Moult defines female justice as "justice aimed at freeing the woman of both the physical and societal implications of the violence" (Moult, 2003). What is female justice in the context of amaBomvana culture? How is it achieved and implemented? Has it ever been implemented? Perhaps by requesting a female cow, her uncles thought they were practising female justice, in their own cultural understandings. Amongst the amaBomvane people, cows are revered and hold special meaning in terms of maintaining healthy relationships between men and women. When a boy impregnates a girl outside of wedlock, he has to pay the girl's family a cow as compensation for his wrong doing. When a man wishes to take a wife, he must pay lobola in the form of cows to his bride's family as a means of thanksgiving. So, in terms of the healer that was harassed by her brother-in-law, her uncles were practising female justice within the context of Bomvana culture by requesting that a cow be paid to the family to make amends.

What I found striking was that the indigenous healers of the area complained that they were not respected in the community, and they blamed this on the biomedical professionals and the church officials. They claimed that the hospital and clinic staff deter people from consulting with indigenous healers in effort to eradicate IHK in the community. They also claimed that the church priests preached incorrect messages about the ancestors by saying that IHK is essentially ancestral worship. In any case, the healers never claimed responsibility for the current status of indigenous medicine. It was always blame shifting and finger pointing. In my observations, the healers of Madwaleni abused alcohol during healing rituals and ceremonies. It is common practice in this area that when there is a ritual, the healers would gather and the family's compound and host an *intlombe* (a healing séance). At the *intlombe*, the healers would often request bottles upon bottles of alcohol from the very individual or family which they have come to heal. In one such occasion, I witnessed the healers requesting three cases of beer, a case of gin, tobacco and a case of cool drink. I found this disturbing to say the least. Why were these "professionals" acting so unprofessionally? I thought as a patient, would I be ok with my doctor getting drunk before he performs an operation on me? So why then were these doctors consuming alcohol before and during a procedure, and why was it accepted? Where was medical etiquette in all of this? Where was the common sense of responsibility as a health professional? These questions are relevant and make for interesting case studies.

4.4 A catalogue of some of the indigenous plants and herbs used to manage illness in Madwaleni

This section of the chapter showcases some of the indigenous herbs and plants that are used to manage illness in Madwaleni. These specific plants first emerged from the Mji (2013) study that inspired this study. The indigenous healers that participated in this study validated Mji's list of herbs (see Appendix C) and offered information about more herbs that were not included in the Mji study. Subsequently, Mji's list was further supplemented with more information by this study such as habitat, scientific names, published literature that has already been issued on some of the plants.

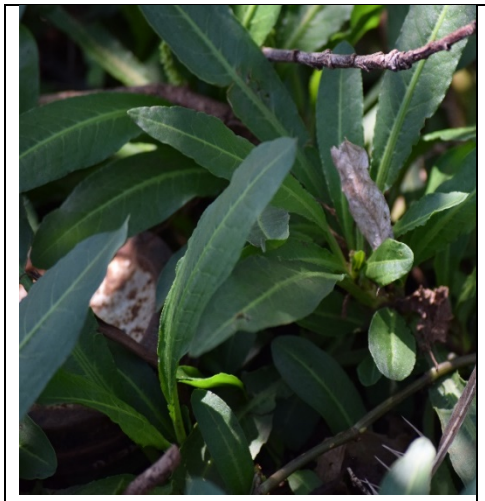
4.4.1 The importance of plants in indigenous medicine:

Previous studies that have researched the indigenous health strategies of rural people have revealed that indigenous herbs and plants play a pivotal role in the healthcare status of indigenous communities (Adams, et al., 2015). Plants are used as both elements of healing and tools of communication between the living and their ancestors, as well as being reservoirs of food (Broster, 1981). Therefore, the natural areas where these plants grow holds a deep spiritual significance for those who use these plants. In fact, many of these indigenous practices found throughout Xhosa land make use of the natural environment and all its resources, be it wild plants and animals, rivers and oceans (Dold & Cocks, 2012). Hence, amaBomvana indigenous herbs and plants are believed to possess a vital life energy that brings about healing. The catalogue presented here showcases some of these indigenous plants of Madwaleni that possess vital life energy.

Table 3. The indigenous medicinal plants of Madwaleni. This table identifies some of the plants that are used to manage illness in Madwaleni and describes the illness managed by each plant, the common methods of preparation for each plant, and describes the ethnobotanical environments in which they grow.

Plant	Scientific name	Common name	Illness treated	Method of preparation	Distribution and habitat
	*Artemisia afra*	Umhlonyane	**Local uses:** The plant is used to treat bronchial ailments such as coughing, fever, chest pain. **Literature uses:** *A. afra* can be used as a natural insecticidal moth repellent. Leaves are placed in socks to combat sweaty feet. Fresh leaves can be inserted into the nostrils to clear blocked nasal passages (Roberts, 1990).	Boil fresh leaves in clean water and drink while warm. 1 cup (125 ml) a day is recommended.	The plant needs a wet habitat to flourish, and hence grows well near rivers or dams, but can also grow near small streams. It grows at altitudes between 20-2 4400m on damp slopes. In Madwaleni the plant grows all year long although in literature it is cited to flower in late summer from March to May. *A. afra* is the indigenous species in this genus, however *A.vulgaris* is naturalized in the Eastern Cape. (Van Wyk, et al., 1997)

	*Trichilia emetic*	Umkhuhlu	**Local uses:** Used as a purgative for treating constipation. Root decoctions are used for the treatment of fever as well as a purgative. **Uses in literature:** Leaf or fruit poultices are used to treat skin diseases such as eczema. It is further used to treat rheumatism and to dress wounds (Hutchings, et al., 1996).	Grind dry bark into fine powder and mix in 1 cup cold water and drink. Is dangerous when overdosed and can cause health complications including severe stomach cramps and burning of the intestines.	The tree can be found on the outskirts of the forest or deep inside where the shrubbier vegetation grows. It occurs naturally in riverine forest and bushveld. The plant is widely distributed in the eastern part of South Africa. Literature notes two subspecies of *T.emetica*, those being *emetica* and *suberosa*. *emetica* is restricted to Southern Africa whereas *suberosa* occurs north of the Zambezi river. The plant is a food source for a variety of animals; the fruit is eaten by monkeys, birds and antelope (Van Wyk, et al., 1997).

	Not found in literature	Idolo lenkonyama	Skin rash.	Grind fresh leaves into a paste. Apply the paste onto the area affected as needed.	Grows in both the forest and the garden. Needs good top soil. It is believed that the best habitat is the forest since the plant grows well in the shade.
	*Polystachya pubescens*	Intelezi	**Local uses:** Intelezi has spiritually protective functions and is used as a bathing agent to ward off evil spirits, to calm fear and to bring luck. **Literature uses:** Because of its showy flowers and relative ease of culture, there is a demand for plants amongst specialist orchid	Dice fresh leaves into small pieces, mix in a 10L bucket of cold water. Use 5L for bathing morning or evening.	This species is found in the coastal forests from the Eastern Cape in the south to Zululand and Swaziland and will not tolerate low temperatures (Acocks, 1988). In Madwaleni it grows in the forest in a dense area shrubby area but needs to be exposed to the sun.

			growers. There are records of the genus being used amongst the amaZulu as a protective charm (Hutchings, et al., 1996).		
	*Rumex ecklonianus L*	Inkodlankondlane	**Local Uses:** Leaves are used to treat pimples, acne and other skin problems such as rash. **Literature uses:** Studies show that the leaves of *R. ecklonianus* are edible when young and can be used as a mild purgative, and also is used in the treatment of chlorosis and anaemia. The plant has shown to have antibiotic and antioxidant properties (Jimoh, et al., 2008).	Grind fresh leaves into a paste and apply on clean affected area.	In Madwaleni *R. ecklonianus* grows in the garden and fields. This herb does not grow well in the forest as it requires a lot of sun exposure and consistent watering to thrive. It most commonly grown as a garden herb in the home.

	Not found in literature	Sivumbampunzi	**Local uses:** Constipation in children. Genital warts. Also used to ward off evil spirits and snakes.	Grind fresh leaves and mix in lukewarm water. Half a cup is recommended for children, and 1 cup for adults.	Needs area with good top soil. Grows best in the garden, but can also be found in the forest under tall trees that provide shade. It was difficult to locate this plant in the forest.

	*Solanum aculeastrum*	Umthuma	**Local uses:** The fruits are used to treat toothache. Uses also include a boiled concoction for treating constipation. **Literature uses:** Literature cites the plant as a poisonous due to it containing alkaloid solanine. It is commonly used as a hedge or as living fencing material for retaining livestock. The fruit is sometimes used as a soap substitute because of its high saponin content (Hutchings, et al., 1996).	The fruit of the plant is used. For toothache, place fruit in an open fire and inhale the smoke. Fruit is dangerous when eaten. For constipation, boil fruit, sieve the mixture and use as an enema. Seeds causes burning of the stomach if not properly sieved.	In Madwaleni the plant grows in the forest in shrubby dense area. The plant can also be grown in the garden in an area with shade. It does not need plenty of water and can survive in dry conditions. Literature cites that *S. aculeastrum* occurs naturally in grassland, woodland and in forest margins, but also in disturbed places. The flowering time is from September to July, peaking in November and March. The fruiting time is from April to January. The plant is found in Limpopo, Mpumalanga, KwaZulu-Natal, Western and Eastern Cape and also in Swaziland (Acocks, 1988).

	*Oxalis smithiana Eckl. & Zeyh.*	Umuncwane	**Local uses:** Used to treat pimples, acne and other minor skin problems such as skin rash. **Literature uses:** The uses of the plant are not commonly documented in literature. "Despite being a speciose component of the Cape Floristic Region at the southern tip of Africa, the southern African Oxalis lineage is systematically poorly understood. Palynological and preliminary phylogenetic studies of the group contrast with the current taxonomy, and indicate the need for further research" (Oberlander, et al., 2011).	Eat fresh leaves. Leaves have a biter sour taste.	Grows in the garden sporadically, does not need to be planted. It is very rare to find in the forest or outside of the garden. The plant is believed to be poisonous for sheep and so it is often grown in a fenced garden space away from livestock.

	Not found in literature	Sikhikhi	**Local uses:** the herb is used to treat earache in children.	Grind fresh leaves and make a paste. Mix paste in cold water to make juice. Pour 2-3 drops into the ear.	Grows in the garden. Needs to be watered regularly. It grows fast and can compete with other garden vegetables such as spinach. In most gardens it is kept controlled by being harvested regularly to avoid competition for water and soil with garden vegetables.
	*Strophanthus speciosus*	Isihlungu	**Local uses:** Used to treat stomach ache and cramps. The amaBomvana also use it before eating *ingcula* (meat of dead livestock killed by illness) to prevent food poisoning and diarrhoea caused by eating meat from animals that died of sickness. **Literature uses:** In literature the plant is described as poisonous	Grind fresh leaves and mix in cold water. Drink 1 cup (125ml)	The plant grows best in the forest in dense shrubby environment. The tree is difficult to spot as very few of the trees exist in Madwaleni. The bark is often harvested for medicine which stunts the growth of the plant. *Strophanthus speciosus* is found in forest margins in the Eastern Cape, KwaZulu-Natal, Limpopo, Mpumalanga, Swaziland and Zimbabwe. (Pooley, 1993)

			and was historically used as a spear poison in Mozambique and Zimbabwe. A very toxic glycoside isolated from plants of the genus *Strophanthus* is used in moderate doses as a cardiac stimulant (Van Wyk & Gericke, 2000).		
	*Lobelia erinus*	Ityholo	**Local uses:** The plant is used for ritual steaming and cleansing. **Literature uses:** Other species of *Lobelia* have reportedly been used as medicinal plants. For example, the roots of *L. pinifolia* have been used in remedies for skin disease, chronic rheumatism and gout (Cupido & Conrad, 2001).	Boil fresh leaves and inhale steam for a duration of 20 minutes.	Out of the 360 species recorded in literature, only 69 occur in South Africa. The genus is found throughout the country and grows in a variety of habitats from sheltered to exposed rocky slopes, sand dunes, sandy flats, shady, damp, coastal mountain slopes and forest floors (Cupido & Conrad, 2001). In Madwaleni, the plant grows in the forest. The plant is easy to spot due to its length and unique leaves. From

					afar it appears to be a sultry plant, but under closer examination, the leaves and bark are quite dry.
	*Rauvolfia caffra*	Umjelo	**Local uses:** The plant is used to treat stomach aches and pains. **Literature uses:** Studies have shown that the latex of *R. caffra* has medical properties and is used to treat diarrhoea and other stomach ailments. The latex also contains	Grind dry bark into fine powder, mix 1 teaspoon of powder with 125ml cold water and drink.	In Madwaleni this tree needs wet soil to grow, and is commonly found growing near rivers and streams. It does not grow on the water, but can be found at a close distance to the river bank. *Rauvolfia caffra* is restricted to coastal forests in east, central and southern Africa. The species occurs in seven provinces in

			alkaloids that are used in preparations for the treatment of high blood pressure and certain mental aberrations. The bark is used as a dressing for wounds and the infusion is used to kill maggots in wounds. Pieces of bark are chewed to treat coughs (Leistner, 2005).		South Africa and in Swaziland. In South Africa, it is found along the coastal belt, in the eastern regions of South Africa, from the Eastern Cape to KwaZulu-Natal, extending further north and inland to Mpumalanga, Limpopo, Gauteng and North-West (Pooley, 1993).

4.4.2 Challenges related to the forest where the medicinal plants of Madwaleni grow.

As described in the catalogue of the various indigenous plants used to mage illness in Madwaleni, the forest in the key environmental resource for these medicinal plants. However, there are issues in Madwaleni with regards to access to the local Dwesa-Cwebe forest, which is managed by the Eastern Cape Tourism Board and the local Mbashe municipality. The healers claim that the Dwesa-Cwebe forest is not only a resource for medicinal plants, but is also a space of spiritual refuge where they go to connect with their ancestral shades that draw their healing powers from the forest. The forest is also used as a teaching space where healers-in-training perform some of their rituals of ukuthwasa. The issues concerning the forest and challenges experienced by the indigenous healers of Madwaleni to gain access to the forest and herbs are presented in the themes below. All names used are pseudonyms.

4.4.2.1 THEME 2: The oppression of indigenous health knowledge in Madwaleni comes in various forms

This theme emerged from the FGDs with the indigenous healers aimed at focusing on the relationship the healers have with the environment their medicines grow. The healers revealed that their access to the indigenous forests where their medicine grows is restricted by the government and this has been affecting the health status of the people of the area. The amaBomvana people of Madwaleni, the natural ethnobotanical environment serves as a place of healing and a source of learnership about cultural IHK strategies. Plants, animals, rivers and oceans all play a pivotal role in the maintenance of solid relationships between the people, the ancestors and the environment.

4.4.2.1.1 SUB-THEME 2.1: Access to the Dwesa-Cwebe forest is restricted

By cultural law, those who practice IHK are trained in the surrounding natural environment such as the forests and rivers. The forest and its resources serve as both a place of collecting resources, but also as a schooling system. The *amaGqirha* healers culturally must conduct some of their studies in the forest under the close supervision of other qualified healers. Despite this important link between the forest and health, local authorities have made it difficult for the amaBomvana of Madwaleni to enter the local Dwesi-Cwebe forest, by placing restrictions on entrance and usage of the forest's natural resources. In FGD8, Indigenous healer Nomakhosi of Hobeni village expressed her concerns over the matter and said:

Our practices in the forest are highly secretive first and foremost. But now we are forced to reveal this information to the government because they are saying they own the forest. We have our sacred places in the forest that we do our rituals that cannot be performed anywhere else. When we enter the forest, only us healers know what to do there and how to do it. But now comes the municipal worker who tells you that you are not allowed to perform your ritual and demands to know what is it you have come to do exactly. If you don't tell him, he chases you out.

She further revealed that in her opinion the municipal restrictions placed on gaining access into the forest has had a negative impact on the spiritual health of the indigenous people of Madwaleni. She stressed the importance of accessing the forest by saying:

Secondly, the herbs and plants we use for making medicine grow in the forest. But the municipality does not allow us to leave with medicine from the forest. The guards will search you on your way out and confiscate any medicine you have collected. I don't know how else they expect us to heal the people without medicine.

Besides the apparent importance of the natural environment to the amaBomvana people, entrance to the forest is becoming even more strictly restricted and the people of Madwaleni fear they might lose their connection to the ancestral messengers and spirits and consequently to the forest's healing powers. When asked to describe her incidences with the Dwesa-Cwebe Nature Reserve, healer Mama Nowinasi of Cwebe village said:

The guards at the gate remove us from the forest. They say that we make the place dirty. We go there with our goats for ceremony and they turn us away. They tell us to use other smaller forests, whereas the patient has been called to the Dwesa-Cwebe by the ancestors. A lot of people get disappointed when they get to the Nature Reserve gate because they get turned away.

She further explained that when the ancestors have requested that a ceremony be conducted at the Dwesa-Cwebe forest, then the instructions must be adhered to otherwise illness will result. The requested ceremony cannot be performed in another forest because the ancestors will get upset that their instructions were not met. When the ancestors are upset, they do not protect the family from harm, misfortune and illness. She reiterated this point by saying:

When we cannot enter the Dwesa-Cwebe forest and we go to use the smaller forests around Madwaleni, the goats disappear and run away. We take this as sign from the ancestors that they are not happy with us. When this happens the healing ceremony cannot take place.

This situation made her visibly upset. It was clear that this pained her. She expressed her pain by saying:

May God help us and fix this. My bones are sore and painful from this. We have been asking the ancestors to awake and come help us.

As Mama Nowinasi expressed, the forest holds a special significance in the spirituality of the amaBomvana people. However, the forced removal of indigenous healers from the forest is causing broken relationships between the people and their ancestors. The Dwesa-Cwebe forest is sacred to the

indigenous people of Madwaleni as it is a place where this spiritually powerful medicine (amayeza) is found and where the ancestors reside.

Amayeza are used for cultural and spiritual purposes, such as body purification, protection against bad spirits caused by witchcraft and for cultural sacrificial rituals. This finding emerged from a critical incident with an indigenous healer in FGD9 held in Hobeni village. The healer described her experiences of being removed from the Dwesa- Cwebe Nature Reserve and how this affected her health. She said:

There is a place near Gatyana called kwaMabhonya. It is also a part of the Dwesa-Cwebe Nature Reserve. But we do not go there because we do not have the money for it because you must pay to use that place. You must hire the toilets, the kitchen and their pots. Why must we cook in their kitchens on the stove when we are there to perform a cultural ceremony? The reason why we visit the forest is because we want to connect with our ancestors. We want to be outside in nature, make a fire and cook. We want to ask the ancestors to heal us. We do not want to defecate in fancy toilets. We want to use the bush and leave parts of ourselves there. That is how we will receive health.

She emphasized the point that camping outside, cooking food on the fire and being one with the natural environment is all part of the healing process. Forcing campers to use modern toilet facilities and kitchen facilities goes against the culture of the amaBomvana. She said:

We leave everything there, including the bones. That is our culture and that is how we receive good health. We cannot receive that healing while cooking on stoves in the kitchen.

As the healer is explaining, the amaBomvana have an intrinsic spiritual link between their natural environment and health. When the healers go to the forest to conduct a ceremony, it is expected that everyone in attendance will sleep outside on tents made from tree branches, cook food on the fire and relieve themselves in the surrounding bush. All these activities are designed to strengthen the relationship between the living, the ancestors and the natural environment.

The healer further detailed how these restrictions have impacted her own health:

I personally was removed by the guards during my ceremony that was being conducted at the forest and was told to exit the Nature Reserve and go use one of the smaller forests near my village. I was called to the Dwesa-Cwebe forest by my ancestors. They wanted the ceremony to be conducted there so they can heal me. I am now blind, and perhaps that is the reason why.

These sacred rituals are being threatened in Madwaleni by the enforcement of rules and regulations that are insensitive to the culture of the indigenous population. Additionally, the introduction of these rules and regulations has opened doors of mistreatment and abuse of indigenous healers as discussed in the following subtheme.

4.4.2.1.2 SUB-THEME 2.2: The oppression and abuse of indigenous healers by third parties

One of the common threads revealed by the healers is that the officials of the Dwesa-Cwebe Nature Reserve expect all indigenous healers that want to use the nature reserve to apply for permits. The issue with this regulation is that the majority of the healers in Madwaleni have not received formal education, and cannot read or write. The expectation of carrying permits has left this group vulnerable and open to abuse by third parties.

The premise of requiring a legal permit to harvest protected natural resources has not been explained properly to the healers by the Nature Reserve officials, leaving many of the healers confused about the whole issue. The healers revealed that there have been a couple of scams going on in the area where healers have been scammed by con artists who are selling fake permits. Many healers have lost money to these scams. One such healer who fell victim to these scams is healer Mama Nozalo. She expressed her distress in FGD9 when she said:

I have been walking this road for a very long time. I have been to Bhisho. I have attended gatherings in community halls hoping to get these certificates. The people who were selling the certificates wanted a copy of my ID and R300 cash. We left our details and paid money to these people hoping to get our certificates.

She further explained how this has all caused her immense distress that it has even started to affect her overall health.

Look at us. We are looking tethered because we have been walking this long road without any success. At the gate of the forest the security guards tell me my certificate is not legal. Those people lied to us. We have never seen them again and our money disappeared.

The healers refer to permits as certificates as this has been the language used to describe entrance permits to them by these scammers. A lot of the healers were told that these permits will grant them access to the Dwesa-Cwebe Nature Reserve so that they can harvest their medicinal plants and conduct their ceremonies and rituals. They were also promised that these permits would allow them to practice as healers without prosecution. Most of these fake permits do not carry any information about the government department that issued the permit or where to seek more information about its validity. Because most of the healers cannot read or write, these small details have gone unnoticed.

One healer who can read and write described her friend's experience with these fake permits. She said:

Nowinethi has a certificate and she showed me. But when we looked at it closely, we saw that it is not a legal document because it didn't have a number, a government emblem or anything that shows that it was issued by the government. There is not even a police stamp on it. It is fake. And I have never even heard of that healer's organization that is written on it.

The prohibition of indigenous healers from entering the local forest without a permit is problematic because most of the healers in Madwaleni are illiterate and unable to neither apply nor afford these permits and licences. This places them at great risk of abuse by inauspicious parties.

Another apparent driver for healers to purchase these fake permits is fear. The healers are fearful that if they are not in possession of documentation that validates them, then they will be arrested by law enforcement for treating a patient without documentation that proves one is a trained healer. When the investigator asked why she wants a permit, the same healer above said:

The problem is that we need these certificates because we heal people. Sometimes you give someone medicine and they have a negative reaction to it. Then the person can take you to court, and they will win because you do not have any certificate that shows you are a healer. We have medicines and we use the, but we use them in fear. Fear that we will get into trouble.

When the investigator asked about the root of her fear, healer Mama Nozalo of Qatywa reflected:

If you give someone medicine and they get diarrhea, you fear taking them to the hospital because they will ask you what you why you gave the person such medicine. You then become afraid to tell the truth because you fear being taken to court. Because you do not have the right to heal if you do not have a certificate that says you are a healer. You have no right to tell the doctor you used medicine on someone because you cannot prove that you are qualified to heal people.

Describing herself as a healer that also performs minor surgical procedures as a means of healing a patient, healer Mama Matshezi of Cwebe village reported something similar and added how she personally has been threatened with legal action by doctors at Madwaleni hospital:

I have an example of a girl I was healing. I made small cuts on her skin and rubbed medicine on the cuts. She reacted and started to swell badly. I decided to take her to the hospital. When I got there they asked me why did I do that to her. I told them that her circumstances demanded that I give her medicine in this way. I was speaking with my head held tight because I did not have any documents to prove that I knew what I was doing. The doctor told me to never use such medicines again because it is dangerous for patients.

The fear of being arrested or prosecuted for treating patients is a real concern for the healers of Madwaleni. The healers fear that if they cannot prove that they have been trained, nobody will believe them. The permits therefore are more than just pieces of paper for these healers, they are a means of garnering respect and validation from both the biomedical health system and the Dwesa-Cwebe Nature Reserve officials.

4.4.3 A CASE STUDY EMERGING FROM THE STUDY

The second case study emerged from the construction of the catalogue of indigenous plants and herbs of Madwaleni. This second case study showcases the important role that indigenous knowledge plays in the construction of health self-esteem amongst the indigenous population in Madwaleni.

4.4.3.1 Case Study 2: The importance of indigenous knowledge on developing the self-esteem and beingness of the African person

My understanding of the dynamics of gender within the culture of the amaBomvana of Madwaleni shifted drastically when I ventured into the local forest with my local guide. He was a male in his mid-30s, was married and had 3 young children. His youngest was a 6 year old girl. On this excursion, he was going to assist me photograph the medicinal herbs of Madwaleni and the ethnobotanical habitats in which they grew. The fact that I practised biomedicine made people doubt my abilities as a spiritual healer, and they tended to identify me solely by my biomedical knowledge. The universe granted me with an opportunity to reconcile this identity when I ventured out into the local forest with my guide. What struck me during our time at the forest was how this man was radiating both divine masculine and feminine energy when he was talking about the natural resources of his land. He was completely and confidently immersed in his understanding of his place in the universe and how his natural environment was a part of him as he was of it. In most instances when we had been together, I had been the one seen as the only legitimate holder of knowledge because I am affiliated with a university.

In Madwaleni, universities are still associated with whiteness, and whiteness is associated with superiority. But at this time and space, I was the learner and the indigenous man was my teacher. At that space and time, he was the bearer of knowledge. Once he had made that realization, he radiated an air of humble authority that somehow did not fit the typical patriarchal masculinity model I had witnessed during my stay in the area. That is, he did not carry the energy of “I am a man, you are a woman, and therefore I know better than you”. Instead, he was operating from a space of sharing, humility and of loving-kindness towards himself and the natural environment he was describing to me. His aura was golden, as if he had been wearing a blanket of golden light. He differed from the teachers I was accustomed to in the classroom because he was expressing knowledge without duress and ego. At that very moment, he was grounded and secure in his being part of the natural environment. He understood that as a teacher, the knowledge he possessed did not belong to him, but rather was a gift from the Universe. He understood that by sharing it with me was a gift not just to me, but to the world. What I understood to be happening was that this man felt validated at that point.

This then raised within me the question of “What is the role of IHK in the development of self-esteem in the African person?” In indigenous knowledge systems, the source of knowing is not internalized as the innovation of one person, rather it is attributed to the natural universe; the individual, the community, the environment and the ancestral spirits are all part of the process of becoming a knower. During this data

collection trip, it dawned upon me that when we begin to acknowledge the process of becoming a knower in the African context, we can begin to decolonize education in Africa, and consequently we build the blocks that the African person can use to decolonize their mind.

4.5 Relationships between indigenous healers and biomedicine in Madwaleni

This section of the findings chapter showcases the various themes that emerged from the study objectives of describing the relationship between indigenous healers and biomedicine in Madwaleni. There currently exists communication challenges between the indigenous healers and the biomedical professional that operate in the hospital and the clinics. This communication divide has resulted in a veil of secrecy around knowledge, with the indigenous healers feeling apprehensive about sharing their indigenous health knowledge with the biomedical professionals. On the other hand, the biomedical professional feel that the healers' unwillingness to share their knowledge is one of the contributing factors to the strained relationship between the two health systems. These challenges are presented in the themes below. All names used are pseudonyms.

4.5.1 THEME 3: The veil of secrecy around indigenous health knowledge and practices

The *amaGqirha* healers of Madwaleni revealed in FGD10 that they do not trust the intentions of the biomedical professionals with their indigenous knowledge. One of the reasons for this resistance to share IHK is rooted in fear that the ancestors disprove of a healer that shares information outside of ritual context, and an apparent mistrust of the intentions of biomedical professionals.

4.5.1.1 SUBTHEME 3.1: The mistrust of biomedicine causes the veil of secrecy

Healer Mama Mamcirha from Hobeni village explained her reasons for not sharing her knowledge with biomedical professionals when she said:

If the doctors want to know which illnesses we heal, we can tell them. But only the illnesses. We cannot tell them about what we use to heal and how we do it. The ancestors will not allow us to do that. We must hide the information because it is given to us in secret by the ancestors.

The healer feels that biomedical professionals want to steal knowledge from her to use in their own biomedical advancement. Secondarily, the healer feels that biomedicine is attempting to replace indigenous medicine:

What do these doctors want to do with our medicine? To use them as their own and then leave us without a practice as the amaGqirha. Even now our people use the clinics most of the time and we are left without work.

A fellow healer, Mama Nomzamo of Nkanya village expressed that the doctors and nurses from the hospital and the clinics criticize indigenous healers for using indigenous medicines on the patients of the area. These incidents for her make her not trust biomedicine. She said:

Doctors and nurses at the hospital and clinics do not respect indigenous medicine. When someone has used indigenous medicine, they tell them that this medicine is wrong and should never be used again. When someone chooses to use indigenous medicine anyways, they get into trouble with their doctor or nurse. The doctor or nurse shouts at the person and scolds them for using indigenous medicine while on biomedical treatment

And she further added that this reprimanding scared the patients:

The person then becomes afraid to use indigenous medicine again. These doctors do not understand how our medicine works and they reject it without knowing and they are making our people move away from using indigenous medicines.

Healer Nolinde mentioned that her reasons for not wanting to share her knowledge stems from her fear that doctors will take her medicines and convert them to pills, which goes against her beliefs. She explained that:

The problem with the doctors is that they want you to name the plants you are using to make medicine for the sick person. But the way in which we have trained is that you are not allowed to tell anyone about your medicine. This medicine comes from the ancestors.

She further clarified that if she goes against the ancestors, her knowledge will no longer be protected and doctors will steal it from her, use it to make biomedical products in the form of pills and make money off her knowledge:

They know what is inside their pills and some of those medicines are traditional plants such as umhlonyana. They grinded these natural plants and called it pills. But they don't tell us how they made those pills, yet they want us to tell them how we make our medicines. So I too will not tell them what plants I use and how I mix them because they will take my medicines overseas and go make pills from them.

The indigenous healers believe that biomedical professionals are only interested in the exact methods of preparing their medicines so that they can pharmaceutically patent them as their own. On the contrary, the biomedical health professionals of Madwaleni argue that this unwillingness of indigenous healers to share

their IHK strategies makes it difficult for them to properly manage a patient's health if they don't know what other medicinal products the patients is consuming as shown in the second sub-theme.

4.5.1.2 SUB-THEME 3.2: Miscommunication between indigenous healers and biomedicine

In interview 4, a biomedical professional revealed his frustrations that medical staff deal with countless issues related to herbal intoxication on a daily basis and attempts to engage the healers that offer these medicines have been unsuccessful. He said:

> *On a daily basis we deal with issues of herbal poisoning in both children and adults. The patient uses certain herbs given to them by their traditional healer, and sometimes these herbs interact with their medical treatment. In some cases, this causes severe health complications, which we then have to deal with in the hospital.*

The biomedical professional argued that the unavailability of knowledge about what herbs are being administered to patients, how these herbs are being prepared and regulated has resulted in the biomedical professionals of the area rejecting all that is associated with indigenous medicine:

> *We have tried in many occasions to educate the traditional healers about how to handle patients that are on medical treatment, but we have not had much success in that regard. For example, we have tried to inform them that TB and HIV patients who are on treatment should not be given purgatives because they lead to dehydration.*

The biomedical health professionals believe that this challenge can be overcome if the indigenous healers lift the veil of secrecy about their practices and herbal medicines. In interview 5, a clinic nurse said:

> *The first thing that needs to happen is that the traditional healers must come and discuss with us in the clinic about some of the methods they use because we have a lot of questions. We care for the traditional healers and we appreciate their work. There are illnesses that can be treated by them only. Illnesses that we cannot cure at the clinic, such as idliso (stomach hexes) and ibekelo (painful magic hexes) and all those other things. We would like them to share with us what medicine they use on people because people are getting sick sometimes from the medicines of the healers. They must not be afraid to come to the clinic to talk to us.*

And she showed interest in making connections with indigenous healers and lifting the veil of secrecy:

We also want to know them. We don't know who they are.

In terms of describing what the future relationship between biomedicine and indigenous healers should comprise of, she said:

We can help them understand TB and HIV by telling that what they should not do to people who are HIV positive. They must not give people medicines for ukugabha (purgatives). It is dangerous for HIV positive people. We want the traditional healers to know these things.

The veil of secrecy goes both ways, with biomedical professional not knowing much about indigenous heath knowledge. When asked to describe Bomvana indigenous health, in interview 4, a biomedical professional said:

I understand there are 2 big aspects to it. First, a spiritual aspect - that there is a belief that ancestors have a large role to play in health, and that this can be influenced especially by indigenous health practitioners. Second, a physical aspect, that there is knowledge of local flora and how these can be used to bring healing.

This apparent miscommunication between biomedical professionals and indigenous healers seems to be affecting the health of patients. In terms of describing his experiences with indigenous healers and his patients, he said:

I haven't had much personal experience with indigenous healers directly myself, but most of my experiences have been while working with children. This, unfortunately, is likely because they have been the most vulnerable to ill-effects of toxic substances. I've seen a number of (especially very young) children arrive with liver and kidney failure very likely due to substances they received from (what were likely 'bogus', or very inexperienced) healers, and this is a very biased sample, so it's been unfortunately largely a very negative experience for me.

When the investigator enquired about what the exact current relationship between the healers and biomedical professionals is like, he said:

To be honest, I don't think it's a very rosy picture to paint. There isn't a very healthy relationship at all. My colleagues, both doctors and many nurses I work with, have shared in my experiences of poisonings in young children from substances received at healers (and again, these probably represent a tiny minority of these healers if I think how many people consult them), and so my impression on the whole is that there is a very poor or negative relationship, at least from the 'biomedical' side of the table. This

becomes plain when we discuss childhood deaths, some of which have occurred likely due to these substances, but I have also perceived these feelings by why of the kinds of comments that are made by staff when talking about indigenous healer consultations (like a nurse translating and saying to me, "No doc, the baby's mother denies having seen a healer, but I can see she's lying - look at those cuts on his stomach!"). Sometimes nurses asking whether a patient has seen an indigenous healer sounds more like an accusation than a question.

In terms of how the broken relationship between biomedicine and indigenous healers can be repaired, he expressed that:

I guess I might start by saying that I'm actually a critic of biomedicine. The biomedical model for healthcare is quite flawed, and in my studies in Family Medicine we're moving towards a Patient-Centred Care model of healthcare. Basically, one that puts the patient at the centre of all our efforts, along with everything that means as a patient presents not only with a biomedical illness, but presents as a person, within a community, with their apparent physical ailment very often only a symptom of much more going on. So, in that light, I guess if we can make sure that patients remain our focus, rather than our own values (or sometimes egos and preconceptions), they can also become the basis for our relationship - our common ground is that we share the same patients.

When discussing ways in which biomedicine could transform its approach, he further added that:

So in some sense we should really ask our patients how they would like us in the 'biomedical' field to relate to indigenous healers, and vice-versa. They may like to keep things separate (their physical ailments from their 'spiritual' ailments), or may ask to collect their ARVs from their local traditional healer. And that may be an interesting thought in the future.

He also alluded to the ways in which indigenous patients of Madwaleni could be given a platform to express their needs within biomedical care:

At the same time, however, what a patient thinks is best for them isn't always what I think is best for them. I come with my own learning and understanding of the body that a patient doesn't always have, and so I can explain and give information to hopefully help them make better decisions. But at the end of the day treatment also becomes a negotiation between what I want for my patient, and what they want for themselves - shared decision making is hugely important.

He further expressed his desire to reconcile the relationship by providing more spaces of healthy dialogue and knowledge exchange:

So maybe a first step is to start a conversation with our patients about what they'd like. And at the same time maybe start a conversation between traditional healers and 'biomedical' healers to start getting to understand how we might be able to work together and what we can offer each other in order to improve the holistic care of our patients. Working out the logistics of it all remains quite a challenge, I think.

It is not just the biomedical professionals that feel that the apparent lack of communication and co-operation between indigenous healers and biomedical professionals causes a lot of confusion for the patients of Madwaleni, especially if the patient is seeking to use a combination of biomedical and indigenous strategies to treat illness. Healer Tata Madala of Hobeni village explained his concerns about this when he said:

If someone gets sick in the evening, they cannot go to the clinic because it is closed. The person has no other choice but to consult us indigenous healers. As the healer, you must help them. But when they go to the clinic the next day, they lie to the doctors about that they used your medicine.

He also expressed concern that this communication divide that exists between indigenous healers and biomedical professionals negatively affects the patient and places their health at risk.

The person will say to the doctors that they did not take any herbs when they actually did take them. The doctor will not know what type of medicine you as the healer gave the person and will perhaps give the person a dose of medicine that is too strong when mixed with the herbs they have already taken. This is dangerous.

As Tata Madala is revealing, there is an apparent need for better communication between healers and biomedical professionals for the sake of the patents who wish to utilize a combination of both biomedical and indigenous medicines to manage a particular illness.

4.6 Summary of the chapter:

This chapter served to present the findings of this study. Multiple qualitative research tools of presenting the data were utilized, such as tables, figures and diagrams and reflective analysis to describe and present the data. Secondarily, this chapter was presented in the order of four sections that each aimed to answer the study objectives. The first section detailed the various healers of Madwaleni, followed by a description of the illnesses these healers manage. A catalogue showcasing the plants and herbs used by the healers to manage these illnesses was given and the relationships the healers have with these natural environments was described. This was followed by an in-depth analysis of the emerging themes from the data. These themes were discussed in relation to the discussion context in which they emerged.

CHAPTER 5

DISCUSSION OF FINDINGS

5.1 Introduction

This chapter serves as the discussion chapter of this thesis. In this chapter, the findings will be discussed using the study objectives as headings. The purpose of discussing the findings in this way is to provide an analytical context for the data presented so that the reader can gain a deeper understanding of these issues and phenomena. Secondarily, this section provides an in-depth reflection on some of the issues presented in the data using both the academic and psycho-spiritual lenses that indigenous African people use to reflect on circumstances. The reason for using both reflection lenses is to demonstrate the significant contribution that indigenous methods can provide in academic research.

5.2 Identifying the types of indigenous healers of Madwaleni and the illnesses they manage

As Table 1 in the results section shows, the indigenous healers of Madwaleni undergo various types of training processes and procedures based on the type of spiritual vocation one has been called to. These various groups of healers hold a holistic view of health that is inclusive of both the physical and spiritual elements of illness. Mji's work on the indigenous health knowledge of Madwaleni notes that the amaBomvane people view illness as the result of broken relationships between family, community, the ancestors and the environment , therefore for wellbeing to be regained these relationships will need to be re-established through cultural rituals with each directly aimed to the type of relationship that has been broken and what the ancestors require for the reestablishment of the relationship (Mji, 2013). Overall, the indigenous healers of Madwaleni as described in Table 1 fit into the general South African indigenous healing system as observed in the various Nguni indigenous cultures of the country. Mokgobi (2014) notes that the general Nguni South African indigenous healing process follows different key stages to bringing about health where firstly there has to be an identification of the illness and its causes (Mokgobi, 2014).

Amongst the indigenous Nguni peoples as described by Mokgobi, health management is achieved through the process of divination during consultation with an indigenous doctor in the community. The second step in this healing process is the neutralization of the cause of illness either by the removal of source of illness through the use of medicinal plants and herbs, or through ritual sacrifice to appease the patient's clan ancestors that are believed to govern the patient's health (Mokgobi, 2014). The health management descriptions given by Mokgobi are similar to the health strategies used by the amaBomvana, who also can be categorized under the Nguni people. As described in Table 2, various illnesses are managed by the healers of Madwaleni and each specific illness requires a specific healing method and technique. However, this does not mean that intersectionality cannot occur. As showcased in Table 2, some strategies that are used to manage one illness can also be used to manage another illness because sickness is seen as a comprehensive phenomenon that affects various aspects of one's life beyond the physical body. Mji offers clarification for

this outlook of health amongst the amaBomvana by stating that in all the various stages of healing amongst the amaBomvana, the patient's illness is healed within context of family and community because illness affects various parts of community life (Mji, 2013). This is because in Madwaleni, the burden of illness is shared amongst fellow community members and all members partake in the healing process by showing support and Ubuntu to the patient (Mji, 2013). This holistic view of health is not unique to Madwaleni or South Africa, and is observed in other indigenous world cultures (Beyers, 2010).

Anthropologist Dapice affirms that the indigenous health models of North America are based on an understanding of the healing relationship as being based on a series of virtues such as respect; humility; compassion; honesty; truth, sharing, hospitality and divine love (Dapice, 2006). These virtues form the foundation of indigenous care amongst the indigenous North American peoples (Dapice, 2006). Keeping this in mind, the methods of treating illnesses used by the healers of Madwaleni have a very strong spiritual focus rather than a physical focus, which differs greatly from the biomedical methods of managing illness, which tend to focus more on the physical elements of disease.

5.3 Understanding the issue of intersectionality in Madwaleni:

The people of Madwaleni consider indigenous medicine to be an expression of their indigenous religious beliefs, which are rooted in the belief that illness is the subsequent result of intersecting broken relationships experienced within the family, the community, ancestral shades and with the animals and plants that make up the natural environment. Hence, that is why in Madwaleni we find a wide array of indigenous healers who utilize various healing strategies to manage illness. However, throughout all of this difference in practice, there is commonality as all of these healers are bound by the same indigenous landscape. Within this same indigenous healing realm, there is intersectionality with the biomedical health system that operates in the area. This intersectionality comes in two forms; 1) being that within the realm of indigenous medicine, the healers themselves share patients by utilizing various healing ideologies and methods, and that 2) these same indigenous patients are being treated by both indigenous healers and biomedical professionals within the 9 clinics and primary hospital. The issue of intersectionality is not surprising because as literature suggests, indigenous African beliefs do not discourage using a Western medical approach to manage illness because its supporters believe that there are some illnesses that can be effectively treated with Western health care such as tuberculosis, but also there exist some illnesses that Western medicine cannot treat, such as those pertaining to witchcraft, spirituality and ancestral connection which are better managed by indigenous medicine (Good, 1987).

Wreford (2005) argues that throughout Africa, in spite of the introduction of Western medicine and healthcare systems in indigenous African communities, many Africans still rely on indigenous medicine for diagnosis, prognosis and treatment, even in cases of severe illness such as HIV and AIDS (Wreford, 2005).

Literature suggests that indigenous African people do not reject biomedical healthcare, they instead would rather use it as a supplementary tool rather than it existing as the dominant health system. As qualitative researcher White observed in her study of the indigenous people of Ghana, in the Ghanaian indigenous understanding of illness, evil spells and witchcraft are also other ways one could become sick (White, 2015). Therefore many indigenous Ghanaian people believe that certain illnesses which defy Western science can be transmitted through witchcraft, such as infertility, loss of marriage and joblessness (White, 2015). However, as King (2012) argues, the introduction of Western religion, education and healthcare has challenged the validity of the indigenous African philosophy towards understanding and managing illness and has subsequently challenged the intersectionality aspect of indigenous health care (King, 2012). For example, as stated by Kwamwaria & Katola (2012) Western medicine does not generally describe witchcraft as a diagnosis for infertility, and very few medical doctors will accept joblessness as an illness, hence making indigenous people feel neglected an misunderstood in their experiences of illness (Kamwaria & Katola, 2012). Hence, in Madwaleni it is not surprising that the intersectionality of indigenous medicine comes with conflicting spaces as there still exists unreconciled issues within the realm of indigenous medicine with regards to who should manage which illness, including patients who feel that they can move between health providers. Kleinman suggests in his health model that the three arenas of health care can have point of intersection, where some patients move between one or more arenas to manage illness (Kleinman, 1980). As shown by Table 2, patients in Madwaleni utilize various health management strategies from various types of healers.

5.4 The complexity of the realm of indigenous medicine in Madwaleni:

As presented in this study, the indigenous healers of Madwaleni have complex relationships with each other within their realm of indigenous medicine. These complex relationships come in many forms such as competition with each other, abuse of privileges and power, which all take the shape of internal subtle and overt violence. In the results section, the investigator presents interview notes and a case study that both showcase some of this internal violence (both subtle and overt) that occurs within the indigenous health system in Madwaleni. The subtle violence is experienced as conflicts related to superiority including internal competition where the healers compete with one another for patients. This competition is fuelled by the belief that the different modes of spiritual callings have levels of significance and power. The *amaGqirha* apparently believe they are the most highly spiritual healers because their ancestral calling involves *ukuthwasa*. This superiority complex creates conflict within the realm of indigenous healing because it makes the other healers such as the *amaTola* and *amaXhwele*, who utilize other healing modalities feel belittled and undermined. This then raises questions such as 1) are not all indigenous healers of Madwaleni not having a spiritual calling and a gift from the ancestors in equal importance and power? 2) If the indigenous belief is that the ancestors and the environment from which the healing is drawn from are shared, then do these ancestral spirits not care for the people in an equal manner? And 3) if the *amaGqirha* believe

that their modalities of linking with the ancestors are the most superior, then are they not supposed to educate the other healers on how to link with the ancestors with the same tenacity?

This phenomenon might appear as a surprise to the unknowing eye because the realm of indigenous medicine has been historically associated as a realm that operates with humility and without duress (Mji, 2013). It then appears as a surprise to witness the holders of this sacred realm behaving in a way that is rooted in power, greed and competition, aspects one would not easily associate with divine spaces of holistic healing. However, as Mji reminds us, the issues of power, competition and hierarchy are not unique to the realm of indigenous medicine as we also observe these same patterns in Western medicine (Mji, 2013). Within biomedical healthcare, we do observe a sense of hierarchy where doctors are considered more knowledgeable than nurses and other "lower- level" medical staff because there is a belief that doctors have undergone more rigid modalities of training than the other types of medical staff. Could it be possible that the *amaGqirha* healers of Madwaleni have chosen a similar approach to that of biomedical health care and its educational process which is fraught with completion and tend to undermine other healers such as nurses and rehabilitation professionals that are not trained as doctors? This is a topic that requires much attention and investigation in Madwaleni.

5.5 The complexities of violence amongst the healers of Madwaleni:

In terms of the overt violence observed within the realm of indigenous medicine in Madwaleni, the healers have been known to physically abuse each other through rape, beatings and also emotional abuse. As Case Study 1 presents, this violence stems from internalized oppression rooted in the fact that many of the healers in the area have been subjected to abuse and neglect from each other during the training process and also after graduation from indigenous training. The *ukuthwasa* process that *amaGqirha* undergo is incredibly violent in Madwaleni as described in Case Study 1. Many teachers abuse their students through beatings and sexual assault, and because the culture is patriarchal, many of the violence towards women is left unaddressed, or inadequately addressed if the case is taken forward. The healers of Madwaleni also cite that the Apartheid government mistreated them by preventing them from accessing their indigenous forests to harvest medicinal plants. This is not unique to Madwaleni, in fact throughout South Africa it used to be illegal for indigenous healers to practice indigenous medicine through the Witchcraft Suppression Act of 1957 which criminalized indigenous medicine (Moshabela, et al., 2016). What all of this violence has done to the healers of Madwaleni is that it has created an energy of internalized oppression in which the oppressed end up oppressing each other. Mbiti argues that this phenomenon is common throughout African communities that have been colonized, mistreated and subjected to generational violence (Mbiti, 1969). According to Mbiti, this happens because for African people, the struggle of being an African is multi-faceted, as we are a people that have been systematically oppressed, suppressed and subjugated in many levels of life, including the psycho-spiritual level (Mbiti, 1969). The author states that every modern

structure that exists in our modern society teaches the African person that their knowledge is not good enough because it is not Eurocentric in its approach (Mbiti, 1969).

King takes this point further and suggests that what this internalized oppression does is it creates internalized guilt, shame and resentment within the African person for wanting to analyse things using the indigenous African perspective, such as wanting to manage illness using the indigenous health system (King, 2012). For the person who feels the oppression, violence towards others easily becomes an outlet for the expression of their internal personal conflict. Violence against women is a pandemic that has been plaguing the indigenous healing practice in Madwaleni for many generations and it is also an unspoken occurrence. Because of the secretive nature of indigenous medicine, even the most horrific practices within this sacred school of thought have gone unheeded. Moult states that culture cannot be viewed as either all good or all bad, but rather traditions and practices within a culture change according to the area where people live and across time (Moult, 2003). Across many patriarchal cultures around the world such as that of the amaBomvana, certain traditions have been developed by men and emphasize male rights at the expense of women. As a result, there are many aspects of culture and tradition which are oppressive and harmful to women (Moult, 2003).

Mji takes this discussion further by presenting that the exclusion of indigenous knowledge in the education of the African child is a symbolic violence that is often left unresolved and unaccounted for (Mji, 2013). This exclusion creates a large amount of spiritual brokenness and trauma that is so deeply seated that it can even be passed down genetically from generation to generation (Mji, 2013). The violence demonstrated by the healers of Madwaleni towards one another is one element that has resulted from this generational trauma. This type of thinking is not generally permitted in academia, especially in the empirical sciences because as experiential scientists we are taught to be objective and practical in our approaches often at the expense of being spiritually disconnected to the phenomena we observe and describe in our academic enquiries (Etkin & Elisabetsky, 2005). This one-sided view of what defines “empirical” is itself an issue because it quickly leads to the assumption that African indigenous models of enquiry are not experimental and realistic compared to Western knowledge models.

5.6 Describing and cataloguing the herbs used by the indigenous healers of Madwaleni, the environments in which they grow and the relationship the healers have with these environments

In Madwaleni, there are some physical diseases that can be adequately treated with biomedicine, but there are some physical and psycho-spiritual illness that can be managed by using indigenous medicine (Mji, 2013). These medicinal plants and herbs grow in various environments across Madwaleni, such as gardens, rivers and forests, making the natural environment a highly spiritual space for indigenous people. As presented in the findings section, Table 3 showcases the short catalogue of the plants of Madwaleni and how the people of the area utilize these plants and additionally, how they view their properties and importance. It was important to study this link in the presentation of the catalogue because the spiritual link to the natural

environment is of great importance to indigenous African people through the continent (Gqaleni, 2006). Gqaleni states that for many black Africans, indigenous medicines have maintained us for generations and knowledge about these resources and where they grow has been passed down from generation to generation (Gqaleni, 2006). Therefore, natural medicines form part of the South African black identity and heritage and hence it is important that we study indigenous plants for both their medicinal and spiritual significance (Mokgobi, 2014; Gqaleni, 2006). Medicinal plants in other countries have been studied for both their medicinal and spiritual properties, and amongst the indigenous people of North America, medicinal plants form part of the collective cultural identity that binds all members of the community (Rausch & Schlepp, 1994).

According to the University of Ottawa, the medicine wheel is comprised of many elements such as medicinal plants, animals, air, water and fire because the natural environment has a symbolic significance to the indigenous peoples of North America (Ottawa, 2017). Plants that have symbolic significance are sweetgrass, tobacco, cedar and sage (Rausch & Schlepp, 1994). Sweetgrass is used for ritual cleansing and spiritually it is associated with strong virtue, and tobacco is used to connect with the spirit world as it is believed to absorb prayer and to transmit the messages in prayer to the ancestors residing in the spirit world. Cedar is used for purification and to attract positive energy and emotions that sustain emotional balance, and sage is also used for purification that drives away negative energies that lead to illness. It is also is used to bring strength, wisdom and clarity that all contribute to overall spiritual health (Rausch & Schlepp, 1994). This indigenous understanding of health and plant medicine has influenced many alternative health strategies of healing across the field of modern medicine in North America (Ottawa, 2017).

5.6.1 The spiritual significance of medicinal plants in Madwaleni:

As observed in Madwaleni, the indigenous plants, along with the natural environments in which they grow serve to heal illnesses both spiritually and physically. Table 3 showcases the various plants used in Madwaleni for both therapeutic and apotropaic purposes, which is rooted in the natural environment. African religion scholar Mbiti argues that the natural environment is of great importance for African people because for the African person, the physical body and the spirit cannot and do not exist independently from each other (Mbiti, 1969). This connectedness stretches beyond the individual and encompasses the family, the community and the ancestors because when one individual is sick, then when whole community is sick. That is because the word “family” is more encompassing than it is in the West (Mbiti, 1969). As he eloquently explains, “for African people, family stretches in all directions like the branches of a tree to embrace everyone. That means everyone is a mother, a father, brother, a sister, an uncle and an aunt to everyone in the community” (Mbiti 1969, 63). This interlinking circle means that all is shared and there is little or no room for an individual to experience life, including health and illness alone. Health and illness are experienced in both their cultural and spiritual understandings, meaning that the community and the environment participates in bringing the person back to a healthy state because “whatever happens to the individual happens to the community, and whatever happens to the community happens to the individual” (Mbiti 1969,

75). Hence, when a person is unable to heal from a sickness that is either physical or spiritual, the burden of the sickness is shared by all in the community. Natural resources such as plants, herbs, animals, rivers, oceans and forests play a pivotal role in the eradication of illness and in the maintenance of good health because they provide outlets for these relationships to be healed and mended in a practical way (Ademuwagun, 1978).

In Madwaleni, the space of the natural environment is a contested space because since the introduction of Western knowledge systems in Madwaleni, the status of indigenous knowledge has steadily been on the decline (Mji, 2013). One example of the causes of this decline is the introduction of the Dwesa-Cwebe Nature Reserve by the local government. This Nature Reserve is located on the indigenous land of the amaBomvane people, and yet they are not allowed to access it without permits and licences. The excessive policing and restrictions on entry into the local forest has had a severe impact on the status of indigenous health strategies in the area. With indigenous healers being unable to harvest their medicinal materials, the local population has been abandoning their IHK and adopting biomedical strategies that are not familiar or culturally appropriate for certain illness. These illnesses that require the use of indigenous plants cannot be managed effectively if the indigenous healers cannot gain access to these plants. Additionally, as revealed by the study participants, the forest serves as a spiritual and physical place of healing for the amaBomvana people, an energy space where the ancestors reside and look after the health of the living kin by blessing the community with plant and animal medicinal resources. Keeping all of this in mind, it becomes apparent that the heavy policing and restrictions placed on harvesting natural resources for the indigenous people of Madwaleni is not only an attack on the spirituality of these African people but is also an attack on their African concept of “beingness”.

5.6.2 The importance of accessing indigenous knowledge spaces:

Case study 2 showcases the important role that access to indigenous spaces has on the self-esteem of the people of Madwaleni. These spaces appear to have both a cultural and a psycho-spiritual symbolic significance for the indigenous people who utilize these spaces. For black South Africans, the land, the spirits and the energies that exist in our surroundings play a pivotal role in shaping our energy configurations (Soga, 1932). Consequently, these energy configurations affect how we interact with ourselves and with the natural universe. By energy configuration the investigator is referring to the innate cosmic field that exist in each individual. African spiritual philosophy teaches that the human system consists of both the physical and cosmic energy bodies and indigenous knowledge systems serve to inform how to integrate these two bodies in order to maintain complete balance (Mbiti, 1969). What has occurred in Madwaleni, with the indigenous people of that area being denied opportunities to celebrate and honour their African knowledge systems has happened to black people throughout the continent of Africa. The end results of this oppression still live on all around us in Africa and it ends up being the oppressed people that perpetuate that oppression (Kamwaria & Katola, 2012). IKS scholars remind us that we must keep in mind that for the African person, the

exclusion of IKS creates intergenerational trauma and pain that presents itself and perpetuates as violence (Etkin & Elisabetsky, 2005) (Mji, 2013).

5.7 Describing the relationship between indigenous healers and biomedicine in Madwaleni

The findings chapter of this thesis presents critical emerging themes that describe the current relationship between biomedical professionals and indigenous healers in Madwaleni. One key emerging theme is the lack of communication that exists between the two parties. As both the indigenous healers and the biomedical professionals of Madwaleni are pointing out, the communication divide that exists between the two health systems is negatively affecting the healthcare of the patients of Madwaleni. The tension creates a situation of confusion for the patient, in the sense that on one hand the patient is discouraged from using indigenous health knowledge and encouraged to adopt a Western healthcare model to treat disease, while on the other hand this same patient does not possess the Western knowledge and training necessary to fully absorb the particulars of biomedical healthcare. This straddling back and forth of the patient can be interpreted as being a huge interpersonal violence that cause great trauma and distress to the patient and his/her family because the patient is moved between two health systems that do not communicate with each other effectively, leaving the patient confused about which treatment options to utilize to manage the illness.

5.7.1 The issue of the veil of secrecy around indigenous health knowledge:

As the study findings show, due to the highly secretive nature of the *ukuthwasa* process, the *amaGqirha* of Madwaleni blatantly refuse to share any details as to how they diagnose and manage an illness with anyone outside of their scope of practice. This is partly due to the highly sacred nature of the *ukuthwasa* training process, which requires an immense amount of knowledge exchange through ritual and ceremony between the ancestors and the trainee, hence knowledge that is exchanged outside of the ritual context is frowned upon and discouraged. The reason for this resistance to share IHK outside of ritual context is rooted in fear that the ancestors will reject an *iGqirha* that shares his/her knowledge outside of ceremonial context. IHK scholars Dolds & Cocks (2012) argue that the fear from indigenous healers to share their knowledge is fuelled by the cultural understanding of the ancestors as being emotionally explosive spirits that punish transgressions with the utmost vigour should anyone overstep their boundaries (Dold & Cocks, 2012). Consequently, the amaGqirha might honestly be afraid that the ancestors will punish them if they share their knowledge. Which then raises many other questions such as 1) what is the role of ancestral knowledge in healing and who owns this knowledge, the ancestors or the people? 2) If the ancestors draw their power and medical knowledge from the natural environment, then how can they claim ownership over the environment which is supposed to be equally shared by everyone in the community?

Consequently, the biomedical health professionals of Madwaleni argue that this unwillingness of indigenous healers to share their IHK strategies causes distrust and miscommunication between the two parties. The unavailability of knowledge about what herbs are being administered to patients, how these herbs are being

prepared and regulated has resulted in the biomedical professionals of the area rejecting all that is associated with indigenous medicine. The biomedical health professionals believe that this challenge can be overcome if the indigenous healers lift the veil of secrecy about their practices and herbal medicines.
In Australia similar challenges exist between indigenous medicine and biomedicine, where the former feels like the latter could be more transparent about their practices. Campbell & Burgess argue that although it is acknowledged in that in many remote areas in Australia as well as in other countries around the world that it is possible for indigenous medicine to coexist with biomedical healthcare as part of a pluralistic medical system, however it still remains unclear to what extent indigenous medicine is practiced and how it sits with the use of biomedical healthcare in most countries (Campbell & Burgess, 2011). This is because many countries that have indigenous populations operate on national health policies that are not inclusive of the indigenous health systems of their indigenous population groups (Oliver, 2013).

5.7.2 The issue of herbal intoxication and safety of indigenous medicine:

Biomedical practitioners in Madwaleni argue that their scepticism of the efficacy of indigenous medicine is due to the fact that without any ethno-botanical, biomedical or pharmacological scientific data for reference, there is currently no scientific basis for integrating the medicinal products and practices of indigenous medicine into the biomedical health system of the area. Perceptions such as these are highly problematic in an area that is comprised mostly of indigenous people because they serve to maintain oppressive power dynamics that favour biomedicine as supreme and indigenous medicine as substandard. However, the concerns of the biomedical professionals are valid and cannot be ignored because many people have died due to the improper use of indigenous medicines. Mills, Cooper, Seely & Kanfer (2005) inform us that despite routine use of about 400 medicinal plants in South Africa, the pharmacological implications of some of these plants still remain unknown and invalidated (Mills, et al., 2005). Throughout the world, the toxicity of herbal mixtures is of high concern. One of the major health concerns of using indigenous medicine is herbal intoxication, which in some cases causes severe kidney damage (Myhre, 2000).

The concerns of the biomedical professionals in Madwaleni are valid because the use of indigenous medicines throughout the country has had fatal consequences. However, the precise number of all herb-induced fatalities in South Africa is still unknown as many have not been recorded or investigated (Bye & Dutton, 1991). This means that although indigenous medicine has proven to be useful for the people that use it within the cultural context, it can still be dangerous if not used properly. This then raises questions about 1) who takes responsibility for the improper use of indigenous medicine? 2) Is it the patient or the professional that administered that medicine? Within biomedicine in South Africa, there exists several governing bodies that monitor and regulate the practices of biomedical professionals, such as the Health Professionals Council of South Africa (HPCSA). However, for indigenous healers there is currently no formal governing body that regulates the practices of indigenous medicine by law (Moshabela, et al., 2016). There is the Interim Traditional Health Practitioners Council of South Africa, but it is an impermanent organization that currently

has many of its policies stipulated under the Traditional Health Practitioners Act, 2004 (Act 35 of 2004) still being amended by the Ministry of Health (Moshabela, et al., 2016).

5.7.3 The general mistrust of biomedicine by indigenous healers

As expressed in the in-depth interviews and FGDs, the indigenous healers of Madwaleni believe that biomedical professionals from the hospital are only interested in the exact methods of preparing their medicines so that they can pharmaceutically patent them as their own. Marcelin (2006) notes that throughout South Africa, this general mistrust towards biomedicine exists and stems from the famous case of *hoodia gordinii*, a Southern African indigenous plant that was historically used by Khoi healers to reduce hunger in hunters who usually spent the whole day away from home hunting for game (Marcelin, 2006). This leafless succulent plant grows naturally in Botswana, South Africa and Namibia (Van Wyk, et al., 1997). Pharmacologically it acts as an appetite suppressant. Pharmaceutical researchers at a pharmaceutical company who worked with the Khoi healers in Southern Africa converted *hoodia* into a pharmaceutical product that was eventually patented as a drug for weight-loss, with little of the royalties from sales being shared with the Khoi healers (Marcelin, 2006). Hence, if such cases have happened, it is understandable why the indigenous healers of Madwaleni might carry a fear that the same thing will happen to them if they reveal their plants and herbs to any researcher or biomedically affiliated individual.

Since the amaBomvana hold a holistic worldview when it comes to health, biomedicine with its exclusive focus on merely physical disease, has not been able to effectively establish itself as a positive influence in this community. Within the hospitals, patients are being encouraged by biomedical professionals to deter from using indigenous medicines by citing that these medicines are not underpinned by scientific evidence. Mji (2013) argues that this renunciation of the validity of indigenous health knowledge greatly violates and threatens social cohesion amongst the amaBomvana as these are a people who experience illness in both its individual and social understandings (Mji, 2013). Therefore, to denounce a health system that has sustained them for generations is a major violence to the self-esteem, heritage and collective sense of worthiness of the amaBomvana people.

Secondarily, some IKS scholars argue that Western knowledge systems in general still need to acknowledge the damage they have done to the self-esteem of indigenous people (Ademuwagun, 1978). Throughout South Africa, practitioners of Western knowledge systems have through Christian religion, biomedicine and education, taught indigenous people that their IKS was not valid and not important to the world (Mji, 2013). What this has done is create an energy of self-doubt within the indigenous people of this country. Ancestrally, indigenous knowledge systems like that of the amaBomvana people have served to connect African people to their land. The Western school of thought has not only challenged this link, but has attempted to uproot it (Mtuze, 2004).

5.8 Summary of discussion:

Tables 1 and 2 in the findings section showcase the various healers of Madwaleni and the illnesses they manage, as well as the indigenous strategies they utilize. Within this diverse realm of indigenous medicine, a lot of internal conflicts exist between the various healers based on the differences in spiritual vocation and training processes.

Secondarily, the discussion chapter for this study has presented issues pertaining to the conflict that exists between Western knowledge and indigenous knowledge in Madwaleni. The emerging themes that kept resurfacing was that the indigenous people of Madwaleni do not resent the Western knowledge model, they are just pained by the manner in which it has been used as an oppressive tool instead of as a supplementary tool; the people of Madwaleni look up to the hospital as being supreme, with them habitually looking down on their own health system. As suggested by some of the biomedical professionals in Madwaleni, perhaps by establishing spaces of dialogue and reflection between indigenous healers and biomedical professionals would assist in addressing and reconciling some of these conflicts.

CHAPTER 6

CRITICAL RESEARCH OUTCOMES, CONCLUSIONS, RECOMMENDATIONS and REFLECTIONS EMERGING FROM THE STUDY

This sixth and final chapter of the thesis serves as a finalization chapter that puts together all the various topics emerging from the study in order to conclude the study. This section aims to align the golden thread of information that has emerged throughout the various chapters presented in this dissertation. Here, the investigator provides both academic critical reflections and outcomes, as well as shedding light on personal responses to the phenomena she observed and experienced throughout her period working on the thesis.

6.1 Critical research outcomes

The nature of this study has been ethnographic, reflective and qualitative. In its approach, this research has been introspective and utilized both indigenous and academic methods of reflection and analysis. The research outcomes of the study will be presented here in context of the study objectives from which they emerged and were analysed as is fitting for an academic study.

6.1.1 Critical research outcome 1: There exists various types of indigenous healers in Madwaleni

This critical research outcome emerged from the study objective of describing the indigenous healers of Madwaleni and the illnesses they manage. What the study revealed is that there is a wide array of indigenous healers operating in Madwaleni, each with its own specializations and modalities of training and practice.

6.1.2 Critical research outcome 2: There is a wide array of illnesses that are managed by indigenous healers in Madwaleni

The indigenous healers of Madwaleni manage various types of illnesses, ranging from minor heath ailment to major health problems.

6.1.3 Critical research outcome 3: Intersectionality is welcomed amongst the healers of Madwaleni

The various types of indigenous healers in Madwaleni work together to assist during times of illness. Patients are moved between the types of healers in order to bring about maximum health benefits.

6.1.4 Critical research outcome 4: The medicinal plants and herbs used by the healers are found in various ethnobotanical environments around Madwaleni

The medicinal plants and herbs used by the indigenous healers of Madwaleni to manage illness grow in various habitats across Madwaleni, be it gardens, forests, rivers, oceans and valleys.

6.1.5 Critical research outcome 5: The indigenous healers of Madwaleni have unresolved internal conflicts within their own realm

However, despite this diversity in modalities, there exists internal conflict issues between the healers, such as competition, superiority complexities and abuse. All these issues have not been dealt with in Madwaleni and require special attention.

6.1.6 Critical research outcome 6: Access to the indigenous herbs of Madwaleni is restricted and this is negatively affecting the status of IHK in the area

This research outcome emerged from the study objective of describing the herbs used by the indigenous healers of Madwaleni to manage illness and the natural environments in which these herbs grow. The study found that the healers of Madwaleni cannot access the local Dwesa-Cwebe forest in which the majority of their indigenous medicinal plants are found. The Nature Reserve is a highly regulated site managed by the local Mbashe municipality and Eastern Cape Tourism Board. These restrictions have resulted in a decline in the IHK strategies that involve the harvesting of herbs and communication with ancestral shades that utilize the forest as a spiritual outlet. This has left the healers feeling vulnerable and confused about how to gain access to the herbs they need to practice their IHK strategies.

6.1.7 Critical research outcome 7: The indigenous healers of Madwaleni and the biomedical professionals of the area do not trust one another and this broken relationship is negatively affecting the patients

This research outcome emerged from the study objective of describing the relationship that exists between the indigenous healers of Madwaleni and the biomedical professionals that operate in the area. This study found that the broken relationship is rooted in generational trauma that has occurred between the two health system, dating back to when Western religion, education and medicine was first introduced in the area. This unresolved conflict has left many of Madwaleni's patients stuck between two healing modalities that do not trust nor communicate with each other but share a space and patients. This unresolved tension is negatively affecting the health status of the patients.

6.1.8 Critical research outcome 8: The manner in which Western knowledge was introduced in the area of Madwaleni was violent

The manner in which Western philosophy was introduced in Madwaleni was violent in the sense that it aimed to discredit and ignore the indigenous knowledge system that was already existent and operational in the area for many generations. This critical research outcome is an amalgamation of all the key study objectives and emerged throughout the study. What this Masters study has found is that in Madwaleni it appears that biomedical professionals do not hate indigenous healers, and that the healers do not hate their biomedical counterparts but that there might be a deep seated problem with the ancestral shades of that land that reside and protect the living kin, including the animals, plants, rivers, oceans and forest spaces. These ancestral spirits seem to be incredibly upset and traumatized by the manner in which Western knowledge was introduced to the area. For the indigenous healers of Madwaleni to in the future work together with biomedical health professionals, there might be a need for reconciliation whereby forgiveness could lead to repair and healing of these damaged ancestral spaces.

6.2 Recommendations based on critical research outcomes

This section of the chapter provides detailed recommendations from the study to address the issues that have emerged from the critical outcomes. In Madwaleni there are various stakeholders that participate in the realm of indigenous medicine as well as stakeholders in biomedical healthcare. The purpose of this section is to provide an exploration of a possible way forward in terms of how all these various stakeholders can work together for the upliftment of the indigenous people of Madwaleni.

6.2.1 The importance of developing a health model for Madwaleni

6.2.1.1 A need to resolve conflict and abuse amongst indigenous healers of Madwaleni

Considering the cultural understanding of well-being and the determinants of health, the amaBomvana prefer to utilize diverse health management strategies when it comes to managing and treating illness.
As shown by critical research outcome 5, there exists a lot of unresolved tension, trauma and pain between the various groups of healers in the area of Madwaleni due to differences in practice. The practitioners of IHK feel neglected and undermined within their own system because tensions exist between IHK practitioners themselves; reconciliation between the various groups of indigenous healers has not yet occurred. When the indigenous healers of Madwaleni reflect on their role in the community, they site that their roles are to provide health care related support to their community members, but that they also act as custodians of the cultural knowledge. However, the broken relationships between the healers themselves is an issue that needs to be addressed first before the IKS can be integrated with the biomedical system. The unresolved tension between the *amaGqirha* and the *amaTola* is one example of the miscommunication among indigenous healers that creates situations where the IHK system seems disunited and fragmented. This study suggests that perhaps a possible solution to the problem would be to assist the indigenous healers themselves need to start acknowledging each other and sharing IHK among themselves before they can start to share with the biomedical system.

6.2.1.2 Revisiting Kleinman's health model

Critical research outcome 7 show demonstrates the difficult relationship that exists between the indigenous healers themselves, and with the biomedical professionals from the 9 clinics and the hospital. As earlier mentioned in Chapter 1 with regards to Kleinman's health model, there is still room for improvement on the applicability of his model in an indigenous setting like Madwaleni. Although Kleinman presents a clear succinct health model with regards to the popular, the folk and the professionals arenas, limitations to the application of the Kleinman model in Madwaleni had already been highlighted (see Chapter 1) in terms of

the intersectionality between these arenas, including how exactly these three arenas can better communicate with each other in a revised model that is specific to the culture, situation and needs of the people of Madwaleni. This might actually mean that referral systems can happen between the three health arenas as described by Kleinman and that the sharing of pathways of care are a possibility if channels of communication are established.

6.2.1.3 Improving on Mji's current health model for Madwaleni

The Mji (2013) study suggested a rural health model that highlights the possible points of intersection between these three health arenas in Madwaleni and how they can communicate with each other (see diagram below). In the Mji health model, the patient in the home is primarily supported by the older Xhosa women and the elite Xhosa women in the popular arena. This same patient is moved from the popular arena and into the folk arena when they are either referred to a biomedical clinic nurse or to an indigenous healer by the older Xhosa women. From the clinic nurse or the indigenous healer the patient is referred to the professional arena that is occupied by doctors in the secondary hospital. This situation in Madwaleni is unique and requires close attention because the folk arena space is made up of both indigenous healers and biomedical nurses simultaneously. In some cases in Madwaleni, some of the nurses at these biomedical clinics also happen to be trained indigenous healers themselves, resulting in a grey area as one cannot categorize these persons as either biomedical nurse or indigenous healer as they occupy both health systems. For one, this is because the introduction of PHC in many rural areas of South Africa, like Madwaleni, resulted in the proliferation of clinics and biomedical community health centres within indigenous communities that already had their own set of indigenous healers operating in the community. With close examination, these clinic spaces somewhat fall within the folk arena because they are situated in the in-between space between the popular and the professional arenas. In that same in-between space there exists the indigenous healers who also occupy the same folk arena space as the clinics. Hence, it becomes clear that there is room for the two parties to come together to find ways of communication with each other so that the patients that are shared by the indigenous healers and the clinic can be managed effectively.

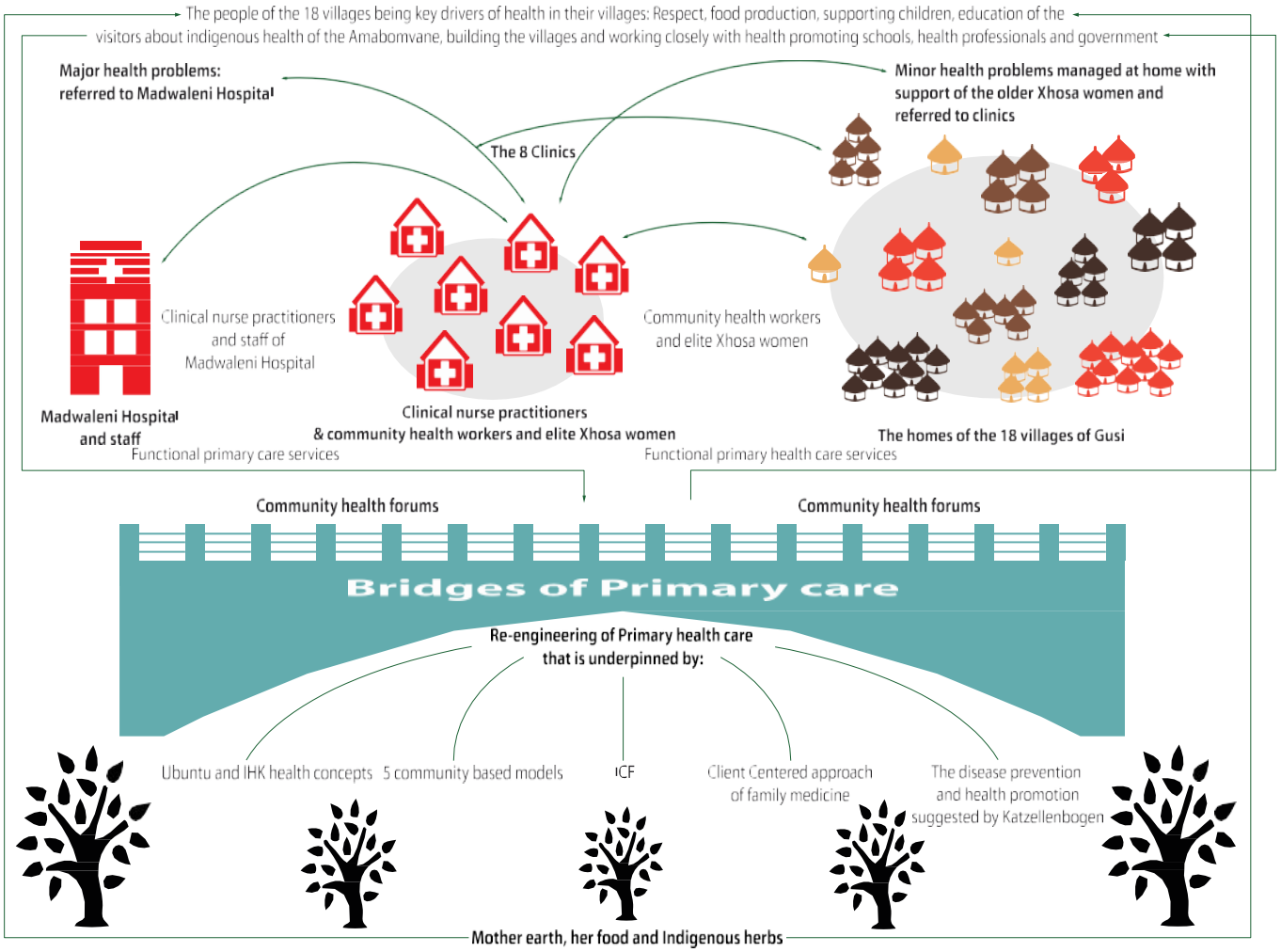


Figure 9: Mji's health model for Madwaleni based on critical research findings (Mji, 2013).

Taking a note from the Mji's health model, this study wishes to improve on the current model of health management model for Madwaleni as suggested by Mji by providing a reconciliation model that details the steps that can possibly be taken to improve the relationship between indigenous healers and biomedical professionals in Madwaleni. This study highlights certain aspects of indigenous health that were not touched upon by Mji. These aspects are discussed below.

6.2.1.3.1 The coalition of indigenous healers of Madwaleni

As the first point in this reconciliation model, this study recommends that before a partnership can be formed between the indigenous healers and the biomedical field, the various groups of indigenous healers themselves need to first share and acknowledge each other without taking any position of superiority over one other. This could possibly be achieved through the coalition of indigenous healers that the investigator assisted the healers of Madwaleni to develop. This study hopes that the existence of this coalition will encourage the healers to discuss issues pertaining to their own health system so that they can progressively

work on improving themselves and their methods, and also possibly utilize the coalition as a space to learn from each other's methods and strategies.

6.2.1.3.2 The dialogue between biomedical health professionals and indigenous healers

Madwaleni is situated in the intersection between biomedicine and indigenous medicine. Biomedicine services this community at a great extent and has effectively assisted in managing physical disease. However, as effective as biomedicine has been in managing some physical illness, it is still a culturally foreign worldview for the indigenous people of this community. Indigenous health practitioners, on the other hand, provide a more culturally acceptable and familiar method of healing. This study recommends that attempts to reconcile these seemingly opposing worldviews is of utter importance if we wish to provide the community of Madwaleni with integrative healthcare approaches that are sustainable to their life situations. This study suggests that this could possibly be done through organizing seminars in which both biomedical professionals and indigenous healers get together to discuss key issues of concern from both parties. These seminars would possibly provide opportunities for biomedical professionals to learn about how the indigenous health system operates, and also the indigenous healers would possibly get an opportunity to learn how biomedicine works so as to combat prejudice from both sides of the fence. The investigator envisions that this space of healthy dialogue would possibly aid in the building of healthy relationship between these two health systems.

6.2.1.3.3 The hosting of regular meetings between the Dwesa-Cwebe Nature Reserve officials and the indigenous healers that need to use the Nature Reserve

The refusal of the environmental affairs officials in Madwaleni to allow indigenous people to harvest natural resources from the Dwesa-Cwebe forest is an issue for the indigenous healers. It is the recommendation of this study that local authorities make attempts to understand the psycho-spiritual relationship the people of Madwaleni have with their natural environment, in efforts to reconcile the pain that has been caused by being prohibited to enter the forest. This could possibly be achieved by allowing the amaBomvana people to enter the Dwesa-Cwebe forest where their medicinal resources grow. In terms of staying true to the concept of conservation, this study suggests that the Dwesa-Cwebe officials host regular meetings with the indigenous healers that wish to utilize the Nature Reserve in order to equip them with knowledge about conservation and maintenance of natural resources so that the Nature Reserve does not get compromised for future generations.

6.3 Final conclusions and summary:

This study recognizes that there still needs to be a broader understanding and a need to award indigenous people in Madwaleni a space to vent, reflect and deflect as part of the healing process. This recommendation is based on the three key emerging superordinate themes from the study, from the Mji health model for Madwaleni, as well as from studying literature that has explored these links in other communities. Studies such as those conducted by Durey & Thompson (2012) amongst the Aboriginal people of Australia reveal that current health policies and practices favour standardised care where the voice of those who are marginalised is often absent. Examining the effectiveness of such models in reducing health disparities requires health providers to critically reflect on whether policies and practices promote or compromise indigenous health and wellbeing - an important step in changing the discourse that places indigenous people at the centre of the problem (Durey & Thompson, 2012). As recommended by the authors, the process of reflection is a critical aspect in the road towards transformation and reconciliation between Western medicine and indigenous medicine.

6.4 Reflection on my experiences throughout conducting this study: An ode to the Higher Self that doeth the healing and reconciliatory work in Madwaleni.

There is an African idiom that tells the story of how the prey and the predator often must take separate but similar journeys in order to understand the complexities of existence in their environmental situations. The idiom reads as follows:

When the gazelle wakes up in the morning it knows that it must run faster than the fastest lion or it will be killed. Every morning when the lion wakes up it knows that it must outrun the slowest gazelle or it will starve to death. It does not matter whether you are a gazelle or a lion, when the sun comes up, you better start running (McDougall, 2009).

Like both the gazelle and the lion, my scholarly pathway has taken me on a long journey in search on fresh new perspectives of familiar landscapes. This journey required me to question the familiar intellectual regime of structured science and health and step into a route away from the dominance of the Western vision. As a professional scholar of biomedicine and as an indigenous healer, my path saw me questioning everything that I thought I knew about health and illness. This was incredibly challenging because I felt strongly that throughout my formal schooling, any topic that sought to even vaguely question Western understandings of "science" were often deemed as not fitting for the scholarly road by my educators. This upset me greatly because I was raised in an indigenous community that practiced various forms of science that were not documented in the school books I read in the classroom.

Green describes it perfectly when she says that "the language of objective modernist scholarship, as it appears in various forms across the globe, is deeply invested in the idea that in order to know, one must be objective rather than subjective. In other words, one must distance oneself from what one knows. Such a theory of knowing is based on the absence, rather than the presence of the person who knows" (Green, 2014). In my journey of conducting this study, I took a note from Green's approach and made the conscious effort to take the contrary view to modern scholarship. Like Green has done in her study, I also had to ask myself the questions of "How has my formal education shaped my understanding of knowledge?" "What is the relationship between my research and the colonial history that has shaped this country?" and "How will I choose to represent the reality of both my experiences and those of the people in my study?" (Green, 2014). What this study has done for me is to allow myself to move with loving kindness. My consciousness has been elevated, and as a result I am now better able to process the thoughts, pain and ideas that I had previously not granted adequate space and time. My thinking was decolonized and my consciousness of my African beingness was reawakened. I can confidently say that I no longer hold the assumption that there is a single reality that can be known. I walk away from this study feeling strongly that the scholarly path should not only embrace that we know, but must also embrace that we also don't know.

The journey of discovering the unknown in terms of indigenous medicine was painful and lonely for me. It is so difficult to acknowledge pain of any kind because pain causes us to retreat to the darkest parts of ourselves because we are ashamed of feeling it. It is a double entendre; we are fearful, and yet are too ashamed to recognize our own fear. So, we pretend that we are brave, valiant and proud instead of acknowledging our fears. One of my greatest teachers, Nelson Mandela, did a very brave thing when he acknowledged his fear. He said “I learned that courage was not the absence of fear, but the triumph over it. The brave man is not he who does not feel afraid, but he who conquers that fear” (Mandela, 2017). At that very moment, with those precise words, he acknowledged his vulnerability and his humanity. His bravery in acknowledging his spiritual and emotional vulnerability could serve as a lesson to us all. We do not need to feel complete all the time. Sometimes being broken is a good thing because it can serve as an opportunity to learn new things.

What I have gathered from my experiences in life and in doing this research, is that for black South Africans, the struggle of “beingness” is multi-faceted (Mtuze, 2004). We are a people that have been discriminated in many fields of life, including the spiritual field (Moyo, 2004). Across Africa, every structure that existed in our past taught black people that we are not good enough. Hence, many black people internalized the guilt, shame and resentment that comes with being black (Mbiti, 1969). It is a bizarre thing, to constantly be in search of a wonder but never believing that wonder exists intrinsically in you. It is a type of spiritual brokenness to hate who you are and to love what you are not. It is a deeply seated trauma, which if not reconciled and healed, is carried from generation to generation (Moyo, 2004). What we often miss when we talk about oppressed groups is the fact that oppressed people carry the guilt and shame of their ancestors in their genes. This guilt and shame consequently takes the shape of victimhood and helplessness (Mji, 2013) (Moyo, 2004).

References

(GNT), G. N. T., 2017. *The Bible Gateway.* [Online]
Available at: https://www.biblegateway.com/passage/?search=Genesis+1&version=GNT#en-GNT-1

Acocks, J., 1988. *Veld types of South Africa. Memoirs of the Botanical Survey of South Africa No.57.* 3 ed. Pretoria: Botanical Research Institute.

Adams, J., Valery, P., Broom, A. & Garvey, G., 2015. Use of Traditional Indigenous Medicine and Complementary Medicine Among Indigenous Cancer Patients in Queensland, Australia. *Intergrative Cancer Therapies,* 14(4), pp. 359-365.

Ademuwagun, Z., 1978. Alafia-the Yoruba concept of health:implication for health education. *International Journal of Health Education,* 21(2), pp. 89-97.

Bahrami, N., 2015. Researcher as an instrument in Qualitative Research: Challenges and Opportunities. *Advances in Nursery & Midwifery,* 25(90), pp. 27-37.

Barrett, S., 1998. 'Alternative' Medicine: More Hype than Hope. In: *Alternative Medicine and Ethics.* Totowa, New Jersey: Humana Press, pp. 1-43.

Berglund, A., 1989. *Zulu Thought-Patterns and Symbolism.* s.l.:Indiana University Press.

Beyers, J., 2010. What is religion? An African understanding. *HTS Teologiese Studies/Theological Studies,* 66(1), pp. 1-8.

Bhat, R. & Jacobs, T., 1995. Traditional herbal medicine in Transkei. *Journal of Ethnopharmacology,* 48(1), pp. 7-12.

Bhoola, K., 1983. *A Clinico-Pathological and Biochemical Study of the Toxicity of Callilepis laureola,* Durban: Thesis, Doctor of Medicine, University of Natal.

Bodenstein, J., 1977. Toxicity of traditional herbal remedies. *South African Medical Journal,* Volume 52, p. 790.

Bouic, P. et al., 2001. Plant sterol/sterolin supplement use in a cohort of South African HIV-infected patients- effects on immunological and virological surrogate markers. *South African Medical Journal ,* Volume 91, pp. 848-850.

Bricki, N. & Green, J., 2007. *A Guide to Using Qualitative Research Methodology ,* London: Medecins Sans Frontieres.

Broster, J., 1981. *Amagqirha: Religion, Magic and Medicine in Transkei.* Goodwood: Afrika Limited.

Bye, S. & Dutton, M., 1991. The inappropriate use of traditional medicines in South Africa. *Journal of Ethnopharmacology,* Volume 34, pp. 253-259.

Callaway, H., 1868. *Nursery Tales,Traditions and Histories of the Zulus in their Own Words.* Springvale, Natal: John A. Blair.

Campbell, D. & Burgess, C., 2011. Potential primary health care savings for chronic disease care associated with Australian Aboriginal involvement in land. *Health Policy,* Issue 99, pp. 83-89.

Canada, Statistics., 2015. *Life Expectancy.* [Online]
Available at: https://www150.statcan.gc.ca/n1/pub/89-645-x/2010001/life-expectancy-esperance-vie-eng.htm
[Accessed 12 July 2018].

Capasso, R., Izzo, A.A., Pinto, L., Bifulco, T., Vitobell, C., Mascolo, N., 2000. Phytotherapy and quality of herbal medicines. *Fitoterapia,* 71((Suppl I)), pp. 58-65.

Clark, P., 2008. Aboriginal healing practices and Australian bush medicine. *Journal of the Anthropological Society of South Australia,* Volume 33, pp. 1-38.

Conrad, P. & Barker, K., 2010. The Social Construction of Illness: Key Insights and Policy Implications. *Journal of Health and Social Behavior,* 51(S), pp. 67-79.

Cook, P., 1931. *Social Organization and Ceremonial Institutions of the Bomvana.* Cape Town and Johannesburg: Juta and Co..

Cupido, C. & Conrad, F., 2001. Lobelias in South Africa. *Veld and Flora,* Volume 83, pp. 118-119.

Dapice, A., 2006. The Medicine Wheel. *Journal of Transcultural Nursing,* 17(3), pp. 251-260.

Dold, A. & Cocks, M., 2002. The trade in medicinal plants in the Eastern Cape Province, South Africa. *South African Journal of Science,* 98(11-12), pp. 589-597.

Dold, T. & Cocks, M., 2012. *Voices from the Forest: Celebrating Nature and Culture in Xhosaland.* Auckland Park: Jacana Media (Pty) Ltd.

Durey, A. & Thompson, S., 2012. Reducing the health disparities of Indigenous Australians: time to change focus. *BMC Health Services Research,* 12(151), pp. 1-11.

Edwards, S. D., 1986. TRADITIONAL AND MODERN MEDICINE IN SOUTH AFRICA: A RESEARCH STUDY. *Social Science and Medicine,* 22(11), pp. 1273-1276.

Endringer, D., Taveira, F., Kondratyuk, T., Pezuto, J., Braga, F., 2014. Cancer chemoprevention activity of labdane diterpenes from rhizomes of Hedychium coronarium. *Revisita Brasileira de Farmacognosia,* 24(4), pp. 408-412.

Etkin, N. & Elisabetsky, E., 2005. Seeking a transdisciplinary and culturally germane science: The future of ethnopharmacology.. *Journal of Ethnopharmacology,* pp. 23-26.

Fenenga, C., Alhassan, R., Duku, S., Janssens, W., Arhinful, D., Hutler, I., 2016. Disparities between Explanatory Models of Health Clients, Healthcare Providers and Health Insurer. *Journal of Health Science,* Volume 4, pp. 1-14.

Foley, P., 2006. Duboisia myoporoides: the medical career of a native Australian plant. *Historical Records of Australian Science,* 17(1), pp. 31-69.

Foster, J. A., 1967. *Red Blanket Valley.* Johannesburg: Hugh Keartland (Pty) Ltd.

Foundation, Donald Woods., 2017. *Madwaleni catchment areas,* Hobeni: Donald Woods Foundation.

Freeman, M. & Motsei, M., 1992. PLANNING HEALTH CARE IN SOUTH AFRICA-IS THERE A ROLE FOR TRADITIONAL HEALERS?. *Soc. Sci. Med.,* 34(11), pp. 1183-1190.

Fu, Y., Wang, Y. & Zhang, B., 2014. Systems pharmacology for traditional Chinese medicine with application to cardio-cerebrovascular diseases. *Journal of Traditional Chinese Medical Sciences,* Volume 1, pp. 84-91.

Gericke, N., Albrecht, C.F., Van Wyk, B., Mayeng, B., Mutwa, C., 2001. Sutherlandia frutescens.. *Australian Journal of Medical Herbalism,* Volume 13, pp. 9-15.

Glass, G. & Hopkins, K., 1984. *Statistical Methods in Education and Psychology, 2nd Edition.* Englewood Cliffs: NJ: Prentice-Hall.

Good, C., 1987. *Ethnomedical Systems in Africa: patterns of Traditional Medicine in Rural and Urban Kenya.* London: The Guilford Press.

Gqaleni, N., 2006. The Status of Traditional Medicine and Medicinal Plants in the Republic of South Africa. *Palmnut Post Vol. 9 No. 2,* pp. 14-15.

Gracey, M. & King, M., 2006. Indigeous health part 1: determinants and disease patterns. *Lancet,* Volume 367, pp. 1859-1869.

Green, E. & Makhubu, L., 1984. Traditional healers in Swaziland: Toward improved cooperation between the traditional and modern health sectors.. *Soc. Sci. Med.,* Volume 18, pp. 1071-1079.

Green, L., 2014. Retheorizing the indigenous knowledge debate.. *Africa-centred knowledges:Cross Fields and Worlds,* pp. 36-50.

Harfield, S., Davy, C., Kite, E., McArthur, A., Munn, A., Brown, Z., 2015. Characteristics of Indigenous primary health care models of service delivery: a scoping review protocol.. *JBI Database of Systematic Reviews and Implementation Reports,* 13(11), pp. 43-51.

Health, Eastern Cape Department., 2015-16. *Annual Report,* Bhisho: Eastern Cape Department of Health.

Health, New Zealand Ministry., 2015. *Maori Health.* [Online]
Available at: https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models
[Accessed 12 July 2018].

Health, New Zealand Ministry., 2015. *Maori health models.* [Online]
Available at: https://www.health.govt.nz/our-work/populations/maori-health/maori-health-models
[Accessed 18 November 2018].

Henriques, A., 2013. Environment, world-view and healing among the Zulu Christians (19th and 20th centuries). *Studia Historia Eccesiasticae,* 39(2), pp. 1-15.

HPCSA, Health Professionals Council of South Africa, 2008. *General Ethical Guidelines For The Health Care Professions,* Pretoria: Health Professionals Council of South Africa.

Hutchings, A., Scott, A., Lewis, G. & Cunningham, A., 1996. *Zulu Medicinal Plants: An Inventory.* Durban: University of Natal Press.

IHS, Indian Health Services., 2018. *Indian Health Services.* [Online]
Available at: https://www.ihs.gov/newsroom/factsheets/disparities/
[Accessed 12 July 2018].

IWGIA, International Work Group for Indigenous Affairs., 2017. *Indigenous Peoples in the United States.* [Online]
Available at: https://www.iwgia.org/en/usa
[Accessed 12 July 2018].

IWGIA, International Work Group for Indigenous Affairs., 2017. *Indigenous World.* [Online]
Available at: https://www.iwgia.org/en/indigenous-world
[Accessed 12 July 2018].

Jimoh, F., Adedapo, A., Aliero, A. & Afolayan, A., 2008. Polyphenolic Contents and Biological Activities of Rumex ecklonianus.. *Journal of Pharmaceutical Biology,* 46(5), pp. 333-340.

Joubert, P. & Mathibe, L., 1989. Acute poisoning in developing countries. *Adverse Drug Reactions and Acute Poisoning Review,* 8(3), pp. 165-178.

Joubert, P. & Sebata, B., 1982. The role of prospective epidemiology in the establishment of a toxicology service for a developing community. *South Arican Medical Journal,* 62(23), pp. 853-854.

Kamwaria, A. & Katola, M., 2012. The Role of African Traditional Religion, Culture and World-View in the Context of Post-War Healing among the Dinka Community of Southern Sudan. *International Journal of Humanities and Social Science,* 2(21), pp. 49-55.

King, B., 2012. “We Pray at the Church in the Day and Visit the Sangomas at Night”: Health Discourses and Traditional Medicine in Rural South Africa. *Annals of the Association of American Geographers,* 5(102), pp. 1173-1181.

Kleiman, A., 1980. *Patients and healers in the context of culture.* Berkley: University of California Press.

Kropf, A., 1915. *A Kafir-English Dictionary (2nd ed.).* Alice: Lovedale Press.

Leistner, O., 2005. *Seed plants of southern tropical Africa: families and genera. Southern African Botanical Diversity Network Report.* 26 ed. Pretoria: SABONET.

Li, R., Myers, S.P., Leach, D.N., Lin, G.D., Leach, G., 2003. A cross-cultural study: anti-inflammatory activity of Australian and Chinese plants. *Journal of Ethnopharmacology,* 85(1), pp. 25-32.

Liu, X., Pan, L. & Zhu, Y., 2012. Active chemical compounds of traditional Chinese medicine Herba Leonuri: implications for cardiovascular diseases. *Clin Exp Pharmacol Physiol,* 39(3), pp. 274-282.

Liu, X., Wu, W., Jiang, B., Yang, M., Guo, D., 2013. Pharmacological tools for the development of traditional Chinese medicine. *Trends in Pharmacological Sciences,* 34(11), pp. 620-628.

Luyckx, V. & Naicker, S., 2008. Acute kidney injury associated with the use of traditional medicines. *Nature,* 4(22), pp. 664-671.

Lynch, K. & Feeley, M., 2009. *Gender and Education: Gendered imperatives and their implications for women and men,* UK: European Commission.

Mabona, M., 2004. *Diviners and Prophets among the Xhosa (1593-1856).* Munster: Lit Verlag.

Mander, M., Ntuli, L., Diederichs, N. & Mavundla, K., 2007. Economics of the Traditional Medicine Trade in South Africa. *South African Health Review,* 2007(1), pp. 189-196.

Marcelin, T., 2006. Biodiversity Regulatory Options: Involvement of Rural Communities in Decision Making Processes in South Africa. *The Journal of World Intellectual Property,* 8(6), pp. 809-824.

Mathez-Stiefel, 2012. Can Andean medicine coexist with biomedical healthcare? A comparison of two rural communities in Peru and Bolivia. *Journal of Ethnobiology and Ethnomedicine,* pp. 1-15.

Mazzocchi, F., 2006. Western science and traditional knowledge: Despite their variations, different forms of knowledge can learn from each other. *The European Molecular Biology Organization,* pp. 463-466.

Mbiti, J., 1969. *African Religions and Philosophy.* New York : Anchor Books.

McDougall, C., 2009. *Born to Run: A Hidden Tribe, Superathletes, and the Greatest Race the World Has Never Seen.* s.l.:Knopf.

Mills, E., Cooper, C., Seely, D. & Kanfer, I., 2005. African herbal medicines in the treatment of HIV: Hypoxis and Sutherlandia. An overview of evidence and pharmacology. *Nutrition Journal,* 4(19), pp. 1-6.

Milot, A. & Bryant, L., 2009. The effects of religion and gender on well-being, substance use, and academic engagemet among rural adolescents.. *Youth Society,* pp. 403-25.

Mji, G., 2013. Exploring the health knowledge carried by older Xhosa women in their home situation, with special focus on indigenous knowledge.. *SUNScholar Research Repository,* p. PhD Thesis.

Mokgobi, M., 2014. Understanding indigenous African healing. *African Journal for Physical Health Education, Recreation and Dance,* pp. 20-24.

Moshabela, M., Zuma, T. & Gaebe, B., 2016. Bridging the gap between biomedical and indigenous health practitioners in South Africa.. *South African Health Review,* pp. 83-92.

Moult, K., 2003. *Justice Served? Exploring Alternative Mechanisms To Address Violence Against Women..* South Africa: University of Cape Town.

Moyo, F., 2004. Religion, Spirituality and Being a Woman in Africa: Gender Construction within the AfricanReligio-Cultural Experiences. *Agenda: Empowering Women for Gender Equity No. 61, Religion and Spirituality,* pp. 72-78.

Mtuze, P., 2004. *Introduction to Xhosa Culture.* Alice: Lovedale Press.

Myhre, M., 2000. Herbal remedies, nephropathies, and renal disease. *Nephrol Nurs,* Volume 27, pp. 473-478.

NACCHO, National Aboriginal Community Controlled Health Organization, 2006. *Aboriginal Health.* [Online]
Available at: https://www.naccho.org.au/about/aboriginal-health/definitions/
[Accessed 12 July 2018].

Nakashima, D. & Roue, M., 2002. Indigenous knowledge, peoples and sustainable practice. *Timmerman P9ed) Encyclopedia of Global Environmental Change. 5: Social and economic Dimensions of Global Environmental Change,* pp. 314-324.

National Collaborating Center for Aboroginal Health., 2011. *An Overview of Aboriginal Health in Canada.* [Online]
Available at: https://www.ccnsa-nccah.ca/docs/context/FS-OverviewAbororiginalHealth-EN.pdf
[Accessed 12 July 2018].

Nelson Mandela., 2017. *Nelson Mandela qoutes.* [Online]
Available at: https://www.goodreads.com

New Zealand, Statistics., 2013. *New Zealand Period Life Tables 2010-2012.* [Online]
Available at: http://archive.stats.govt.nz/browse_for_stats/health/life_expectancy/NZLifeTables_HOTP10-12.aspx
[Accessed 12 July 2018].

Oberlander, K., Dreyer, L. & Bellstedt, D., 2011. Molecular phylogenetics and origins of southern African Oxalis. *Taxon,* 60(6), pp. 1667-1677.

Ohajunwa, C. & Mji, G., 2018. The African Indigenous Lens of Understanding Spirituality: Reflection on Key Emerging Concepts from a Reviewed. *Journal of Religion and Health,* Issue 2018, pp. 1-15.

Ohenjo, N., Willis, R., Jackson, D., Nettleton, C., Good, K., Mugarura, B., 2006. Health of Indigenous people in Africa. *Lancet,* Issue 367, pp. 1937-46.

Oliver, S., 2013. The Role of Traditional Medicine Practice in Primary Health Care within Aboriginal Australia: a review of the literature. *Journal of Ethnobiology and Ethnomedicine,* pp. 1-8.

Pandley, M., Rastogi, S. & Rawat, A., 2013. Indian Traditional Ayurvedic System of Medicine and Nutritional Supplementation. *Evidence-Based Complementary and Alternative Medicine,* Volume 2013, pp. 1-12.

Peltzer, K., 2000. Community Perceptions of Biomedical Health Care in a Rural Area in the Northern Province South Africa. *Health SA Gesondheid Vol 5 No. 1,* pp. 55-62.

Peltzer, K., 2009. Indigenous health practitioners in South Africa. *Lancet,* pp. 956-7.

Pezella, A., Pettigrew, J. & Miller-Day, M., 2012. Researching the researcher-as-instrument: an exercise in interviewer self-reflexivity. *Qualitative Research: QR,* 12(2), pp. 165-185.

Pilch, J., 1995. Insights and models from medical anthropology for understanding the healing activity of the Historical Jesus. *SBL Seminar Papers,* pp. 314-337.

Pooley, E., 1993. *The complete field guide to trees of Natal, Zululand and Transkei.* Durban: Natal Flora Publications Trust.

Posey, D., 1999. *Cultural and Spiritual Values of Biodiversity.* Denmark: Phonix Trykkeriet.

Qi, D. Z., 2017. *Essential medicines and health products.* [Online]
Available at: http://www.who.int/medicines/areas/traditional/definitions/en/

Qi, F.H., Wang, Z.X., Cai, P.P., Zhao, L., Gao, J., Kokudo, N., 2013. Traditional Chinese medicine and related active compunds: A review of their role in hepatitis B virus infection. *Drug Discov. Ther.,* Volume 7, pp. 212-224.

Raheim, M., Magnussen, L., Sekse, J., Lunde, A., Jacobsen, T., Blystad, A., 2016. Researcher- researched relationship in qualitative research:. *International Journal of Qualitative Studies on Health and Well-being,* Volume 11, pp. 1-12.

Rausch, D. & Schlepp, B., 1994. *Native American voices.* Grand Rapids: Baker Books.

Roberts, M., 1990. *Indigenous healing plants.* South Africa: Southern Book Publishers.

Ru, J., Li, P., Wang, J., Zhou, W., Li, B., Huang, C., 2014. TCMSP: a database of systems pharmacology for drug discovery from herbal medicines. *J Cheminformatics,* 6(1), p. 13.

Samy, R., Ignacimuthu, S. & Sen, A., 1998. Screening of 34 Indian medicinal plants for antibacterial properties. *Journal of Ethnopharmacology ,* 62(2), pp. 173-181.

Sandifer, P. & Sutton-Grier, A., 2014. Connecting stressors, ocean ecosystem services, and human health. *Nat. Resour. Forum,* Volume 38, pp. 157-167.

Sandifer, P., Sutton-Grier, A. & Ward, B., 2015. Exporing connections among nature, biodiversity, ecosystem service, and human health and well-being: Opportunities to enhance health and biodiversity conservation. *Ecosytem Services,* Volume 12, pp. 1-15.

Setswe, G., 1999. The Role of Traditional Healers and Primary Health Care in South Africa. *Health SA Gesondheid,* 4(2), pp. 56-60.

Shahid, S., Blean, R., Bessarab, D. & Thompson, S., 2010. "If you don't believe it, it won't help you": use of bush medicine in treating cancer among Aboriginal people in Western Australia. *Journal of Ethnobiology and Ethnomedicine,* 6(18).

Sheikh, Y., Maibam, B., Biswas, D., Laisharm, S., Borah, J., 2015. Anti-diabetic potential of selected ethno-medicinal plants of north east India. *Journal of Ethnopharmacology,* Volume 171, pp. 37-41.

Smith, C. & Snell, P., 2009. *Souls in Transition: The Religious & Spiritual Lives of Emerging Adults.* Oxford: Oxford University Press.

Smith, N., 1991. Ethnographic field notes from the Northern Territory, Australia. *Journal of the Adelaide Botanical Gardens,* 14(1), pp. 1-65.

Soga, J., 1932. *The Ama-Xosa: Life and Customs.* Alice: Lovedale Press.

Steenkamp, V., Stewart, M. & Zuckerman, M., 1999. Detection of poisoning by Impila (Callilepis laureola) in a mother and a child. *Human & Experimental Toxicology,* 18(10), pp. 594-597.

Stephens, C., Nettleton, C., Porter, J., Willis, R., Clark, S., 2005. Indigenous peoples' health-why ae they behind everyone, everywhere?. *Lancet,* Volume 366, pp. 10-19.

South African San Institute., 2017. *San Code of Research Ethics.* [Online]
Available at: http://trust-project.eu/wp-content/uploads/2017/03/San-Code-of-RESEARCH-Ethics-Booklet-final.pdf
[Accessed 10 July 2018].

Tourism, Eastern Cape Province., 2018. *Adventure Province Eastern Cape.* [Online]
Available at: http://www.visiteasterncape.co.za/nature-conservation/provincial-parks/dwesa/
[Accessed 10 July 2018].

Twine, W., Moshe, D., Netshiluvhi, T. & Siphugu, V., 2003. Consumption and direct-use values of savanna bio-resources used by rural households in Mametja, a semi-arid area of Limpopo Province. *South African Journal of Science,* Volume 99, pp. 467-73.

UN, United Nations., 2008. *United Nations Declaration on the Rights of Indigenous Peoples,* Geneva: United Nations .

University of Ottawa., 2017. *Society, the individual and Medicine.* [Online]
Available at: http://www.med.uottawa.ca/SIM/data/Vul_Indigenous_e.htm#medicines
[Accessed 12 July 2018].

Van Wyk, B. & Gericke, N., 2000. *People's plants: a guide to useful plants of southern Africa.* Pretoria: Briza Publications.

Van Wyk, B., VAn Oudtshoorn, B. & Gericke, N., 1997. *Medicinal plants of South Africa..* Pretoria: Briza Publications.

Venter, C. & Joubert, P., 1988. Aspects of poisoning with traditional medicines in southern Africa. *Biomedical and environmental sciences : BES,* 1(4), pp. 388-391.

Victor, J., Smith, G. & Van Wyk, A., 2016. History and drivers of plant taxonomy in South Africa. *Phytotaxa,* 269(3), pp. 193-208.

Visagie, S. & Schneider, M., 2014. Implementation of the principles of primary health care in a rural area of South Africa. *African Journal of Primary Health Care Family Medicine,* pp. 1-10.

Wainwright, J., Schonland, M. & Candy, M., 1977. Toxicity of Callilepis laureola. *South African Medical Journal,* Volume 52, pp. 313-315.

Whitehead, T., 2004. *What is Ethnography? Methodological, Ontological, and Epistemological Attributes,* College Park: University of Maryland.

White, P., 2015. The concept of disease and health care in African traditional religion in Ghana. *HTS Teologiese Studies/Theological Studies,* 71(3), pp. 1-7.

WHO, World Health Organization., 2001. *Legal Status of Traditional Medicine and Complementary/Alternative Medicine: A Worldwide Review,* Geneva: WHO.

WHO, World Health Organization., 2017. *Preamble to the Constitution of WHO as adopted by the International Health Conference as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO,.* [Online]
Available at: http://www.who.int/suggestions/faq/en/

WHO, World Health Organization., 1978. *Social Determinants of Health.* [Online]
Available at: http://www.who.int/social_determinants/tools/multimedia/alma_ata/en/
[Accessed 12 July 2018].

WHO, World Health Organization., 2007. *Health of indigenous peoples.* [Online]
Available at: http://www.who.int/mediacentre/factsheets/fs326/en/
[Accessed 12 July 2018].

WHO, World Health Organization., 2018. *Social determinants of health.* [Online]
Available at: http://www.who.int/social_determinants/sdh_definition/en/
[Accessed 13 July 2018].

Williams, E., Guenther, J. & Arnott, A., 2011. *Traditional Healing: a literature review. Working paper series 2: Evaluation and policy. No.2, Covaluator Network.* [Online]
Available at: http://www.covaluator.net/docs/S2.2_traditional_healing_lit_review.pdf.

Winkel, C., 2010. *Perceptions of people living in the catchment area of Madwaleni Hospital, South Africa regarding the health and social problems facing the community,* Dresden: Dresden University of Technology.

Wreford, J., 2005. Missing Each Other: Problems and Potential for collaborative efforts between biomedicine and traditional healers in South Africa in the time of AIDS. *Social Dynamics,* 31(2), pp. 55-89.

Wynberg, R., 2004. *Regulating Access to South Africa's Biodiversity and Ensuring the Fair Sharing of Benefits from its Use.* [Online]
Available at: https://www.researchgate.net/publication/260079942

APPENDICES

Appendix A
Ethics Approval Forms

This study was approved by the Stellenbosch University Health Research Ethics Council (HREC) in 2017 and approval was renewed in 2018.

2017 form:

VERSITEIT•STEL BOSCH•UNIVI

Approval Notice
New Application

16-Aug-2017

Ethics Reference#: S17/05/101

Title: Exploring and Identifying the Indigenous Healers of Madwaleni and their Relationship with Ethnobotany and Healthcare.

DearMsTMay

The New Application received on 12-May-2017 was reviewed by members of Health Research Ethics Committee (HREC) via expedited review procedures on 15-Aug-2017 and was approved.

Please note the following information about your approved research protocol: Protocol Approval Period: 15-Aug-2017 - 14-Aug-2018
Please remember to use your protocol number (Sl 7/05/101) on any documents or correspondence with the HREC concerning your research protocol.

Please note that the HREC has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

After Ethical Review:

Please note a template of the progress report is obtainable on www.sun.ac.za/rds and should be submitted to the

Committee before the year has expired.

The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly for an external audit

Translation of the consent document to the language applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372 Institutional Review Board (IRB) Number: IRB0005239

The Health Research Ethics Committee complies with the SA National Health Act No. 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles, Structures and Processes 2015 (Department of Health).

Provincial and City of Cape Town Approval

Please note that for research at a primary or secondary healthcare facility, permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@l) gwc.gov.za; Tel: +27 21483 9907) and Dr Helene Visser at City Health (He)ene.Visser@cal)etown.gov.za: Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

We wish you the best as you conduct your research.

For standard HREC forms and documents, please visit: www.sun.ac.za/rds

If you have any questions or need further assistance, please contact the HREC office at 0219389677.

Yours sincerely,

Health Research Ethics Committee 1

Afdeling Navorsingsontwildrnllng en -Stcun o Research Development and Support Division

Posbus/PO Box 241 • Cape Town 8000 • Suid Afrika/South Africa
Tel: +27 (0) 219389677

2018 form:

UNIVERSITEIT
STELLENBOSCH
UNIVERSITY

Progress Report Approval Letter

21/06/2018

Project Reference #: 3605

Ethics Reference #: S17/05/101

Title: Exploring and Identifying the Indigenous Healers of Madwaleni and their Relationship with Ethnobotany and Healthcare. Dear Miss Thandokazi May,
Your request for extension/annual renewal of ethics approval dated 31 May 2018 refers.

The Health Research Ethics Committee reviewed and approved the annual progress report you submitted through an expedited review process. The approval of this project is extended for a further year.
Approval date: 21 June 2018

Expiry date: 20 June 2019

Kindly be reminded to submit progress reports two (2) months before expiry date.

Where to submit any documentation

Kindly note that the HREC uses an electronic ethics review management system, *Infonetica*, to manage ethics applications and ethics review process. To submit any documentation to HREC, please click on the following link: https://applyethics.sun.ac.za.

Please remember to use your Project ID [3605] and Ethics Reference Number [S17/05/101] on any documents or correspondence with the HREC concerning your research protocol.

National Health Research Ethics Council (NHREC) Registration Numbers: REC-130408-012 for HREC1 and REC-230208-010 for HREC2 Federal Wide Assurance Number: 00001372

Institutional Review Board (IRB) Number: IRB0005240 for HREC1 Institutional Review Board (IRB) Number: IRB0005239 for HREC2

The Health Research Ethics Committee complies with the SA National Health Act No. 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki and the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles, Structures and Processes 2015 (Department of Health).

Yours sincerely,

[redacted]

Health Research Ethics Committee 1

Appendix B

Consent forms

The consent forms for this study were approved by the Stellenbosch Health Ethics Research Council (HREC), Ethics reference #: S17/05/101

English form:

PARTICIPATION INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT

Exploring and Identifying the Indigenous Healers of Madwaleni and their Relationship with Ethnobotany and Healthcare.

PRINCIPAL INVESTIGATOR: Ms THANDOKAZI MAY (MSc Candidate)

ADDRESS: Division of Clinical Pharmacology, Faculty of Medicine and Health Sciences, Stellenbosch University

CONTACT NUMBER: [redacted]

E-MAIL: [redacted]

This informed consent form has two parts:

- Information sheet detailing information about the study
- Certificate of Consent for signatures if you choose to participate

PART 1: Information Sheet

Introduction

You are invited to join a study that aims to document the indigenous healers of the Madwaleni area, as well as to catalogue the ethnobotanical plants that they use in their healing practices. You do not have to decide today whether you want to participate in this research. You are free to talk to anyone you feel comfortable with about this research study.

Please feel free to ask the investigator about any parts of the research study that you do not understand. Your participation in this study is completely voluntary and you are free to decline to participate if you wish to. If you decline to participate, this will not negatively affect you in any way. If you decide to participate in the study, you are free to withdraw at any point of the research.

Why is this study being done?

Indigenous healers play a very important role in maintaining health in their communities. In rural areas, they are often the primary health care professionals that offer medical care for the sick. We want to find out who the indigenous healers of the Madwaleni area are so that we can understand who, apart from the doctors and nurses in the clinics and hospitals, people in this community consult when they are sick. We also want to learn about the various plants that the healers use to treat illness so that we can better understand the indigenous knowledge system of Madwaleni. Apart from being primary health care professionals, indigenous healers are the primary holders of indigenous knowledge and they play a crucial role in the maintaining of indigenous knowledge systems. South Africa has a long tradition of natural plant research and many regulatory and advisory boards have put in place policies that aim to guide and regulate research into traditional medicines. As the holders of intellectual property of IKS, this research wants to understand the deeper role that holders of IKS can play in the protection and development of ethical IKS academic strategies for both present and future generations.

Why are you being asked to take part?

We are inviting you to participate in this study because we feel that your experience as somebody who provides health care for the people of this community can help us understand the interaction between indigenous knowledge and health in Madwaleni.

What will happen if you choose to take part in this study?

If you accept to take part in this study, we will ask you to take part in a Focus Group discussion in the presence of other indigenous healers of your area. A set of discussion questions will be asked by the interviewer. You can either choose to answer the questions or not. You do not have to answer any questions that you are not comfortable answering.

If you wish to talk to the interviewer in private, then a one-on-one interview can be arranged. The interview will take place in the privacy of your place of residence or work.

During the discussion, the interviewer will sit down with the group of healers in a comfortable private space. If you do not wish to answer any of the questions in the discussion, you may say so and the interviewer will move on to the next question. The interview will be conducted in the language that you feel comfortable with. The discussions and interviews will be recorded by the interviewer.

During the discussion and interview, some personal information may be collected, such as gender, age, ethnicity and years of practice. We will also ask you questions about:

- Your health/medical practice: How long have you been working as an indigenous healer? On average, how many patients do you see a day? What sort of ailments do you treat in your practice?
- Your views on health care: What is health, and how is it achieved and maintained within the home and community? What is the role of healers in their communities when it comes to maintaining health?
- Your experience with treating illness: What types of illness do indigenous healers treat? How do indigenous healers manage or treat illness? What herbs and plants do healers use to treat illness?
- Potential improvement to health care in your community: In your opinion, in what way can indigenous healers and their knowledge of indigenous medicine be integrated into the current health care system in your community?

The information collected will help the investigator find ways to assist the indigenous healers in forming their own coalition as the holders of indigenous knowledge, where they will have the platform to discuss and develop solutions to the challenges faced by indigenous healers in the Madwaleni area and all its surrounding villages. Some of these

challenges have been underpinned by years of discrimination against practitioners of indigenous health knowledge (IHK) by previous governments. This research wishes to assist in eliminating derogatory social attitudes towards indigenous healers and the practices of indigenous medicine by collectively increasing their visibility as essential providers of health care in the area and by promoting the IKS of indigenous healers.

What happens if you refuse to take part?

If you choose not to participate in this research, nothing will happen to you and you will not be negatively affected in any way whatsoever. Your participation in this study is completely voluntary. If you had chosen to participate, but then change your mind at a later stage, you are free to withdraw from the research at any point.

Who will see the information collected from this research?

The information recorded during this research will be kept confidential during the study. Only investigators directly involved in this study will have access to this information and any other sensitive information. The real names of the participants will not be shared with the University or in any publication of the data collected from this study. Pseudonyms will be used in place of real names. A pseudonym is a fake name that will be used when referring to a participant. The investigator will offer each participant an opportunity to choose a pseudonym of their liking, or the investigator can choose one if the participant wishes to. This will be done in order to protect the participant's confidentiality. The recording tape and all other materials will be stored in a safe, locked cabinet that is only accessible to the investigator. Once the information has been analyzed, the investigator will submit the findings of the study for a thesis at the Faculty of Medicine and Health Sciences at Stellenbosch University.

How many people will take part in this study?

We will be interviewing 20-30 indigenous healers of each area in the Madwaleni region.

What are the risks involved in this study?

There is no risk to your health or safety by participating in this study. We are asking you to share with us your personal experiences pertaining to the health care you have provided or are currently providing in your community. If at any stage, you feel uncomfortable you can refuse to participate.

Who will the results be shared with?

The data collected from this research will be analyzed and compiled into a report to be submitted to the University of Stellenbosch. A catalogue of the plants used by indigenous healers in Madwaleni will be documented and shared with the University and the National Research Foundation (NRF). Each participant will receive a summary of the research findings once the study is completed. Following the presentations and meetings with the University, we will publish the results so that other interested people may learn from the research. The results will be presented to the academic community through international and national conferences, scholarly journal articles and reports.

Will you receive any reward for participating in this research?

No, there will be no monetary incentive or compensation for participating in this research. However, all lunches and meals during visits will be provided for by the investigator.

Who do I talk to or contact if I have any questions about the research study?

If you have any questions, you can ask them now or later. If you wish to ask questions later, you may contact [redacted]

The Stellenbosch University Faculty of Medicine and Health Sciences Research Ethics Committee can be contacted on 021 938 9677 in case the participant has any questions regarding their rights and welfare as research participants in this study. You can also ask questions via email to the administrator at the Ethics office at elr@sun.ac.za

This study has been reviewed by the Stellenbosch University Human Research and Ethics Committee, which is a committee whose task is to ensure that research participants are protected from harm. This study will be conducted per the ethical guidelines and principles of the International Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

PART II: Certificate of Consent

Participant:

I (name)……, agree to take part in the research study entitled: Exploring and Identifying the Indigenous Healers of Madwaleni and their Relationship with Ethnobotany and Healthcare.

I declare that:

- I have read and understood the information stated in this document.
- I have had the opportunity to ask any questions that I had pertaining to this study and that all my questions have been answered to my satisfaction.
- I consent voluntarily to participate in this study.
- I do not waiver any of my rights by participating in this study.
- I may choose to withdraw from this study at any point and I will not be penalized or judged in any way.
- I have been given a copy of this consent form.

Signed at (place)……...

Signature of participant…… Signature of witness…….

Date……. Date……..

Declaration by investigator

I (name)…… declare that:

- I have explained the information in this document to the participant.
- I encouraged him/her to ask questions and took adequate time to answer these questions honestly and truthfully.
- I confirm that the participant was not coerced or manipulated into taking part in this study. Consent was given freely and voluntarily.

Signed at (place)…….

Signature of investigator……... Signature of witness……..

Date……. Date……

isiXhosa form:

INCWADANA ENGOLWAZI NGOMTHATHI-NXAXHEBA

KUNYE NEFOMU YEMVUMELWANO

ISIHLOKO SEPROJEKTHI YOPHANDO: Ukuphonononga Nokuphawula Iinyangi Zesintu
zaseMadwaleni Noludlwelwane bazo Namachiza esintu Nezempilo

INOMBOLO YONXULUMANO: [redacted]

UMPHANDI OYINTLOKO: Thandokazi May (MSc candidate)

IDILESI: Division of Clinical Pharmacology, Faculty of Medicine and Health Sciences, Stellenbosch University

INOMBOLO YOQHAGAMSHELWANO: [redacted]

Uyamenywa ukuba athathe inxaxheba kwiprojekthi yophando. Nceda thatha ixesha lokufunda ulwazi oluvezwe apha, oluzakuthi luchaze iinkcukacha zale projekthi. Nceda buza nayiphina imibuzo emalunga nayiphina indawo ongayiqondiyo ngokupheleleyo kubasebenzi besi sifundo okanye kugqirha. Kubaluleke kakhulu ukuba waniliseke ngokupheleleyo yinto yokuba ucacelwe kakuhle ukuba yintoni ebangwa sesi sifundo kwaye ungabandakanyeka njani. Kwakhona, ukuthatha kwakho inxaxheba **kungentando yakho ngokupheleleyo** kwaye ukhululekile ukuba ungarhoxa ekuthatheni inxaxheba. Ukuba uthi hayi, oku akusayi kuchaphazela ukungavumi kwakho nangayiphina indlela. Ukwakhululekile ukuba uyeke kwesi sifundo naninina, nkqu nokokuba uyavuma ukuthatha inxaxheba ekuqaleni.

Olu phando luvunywe ziinqobo ezisesikweni **zeKomiti yoPhando Lomntu kwiYunivesithi yaseStellenbosch** kwaye luzakwenziwa ngokwemigaqo esesikweni lophando elamkelekileyo kwiSaziso sehlabathi sika-Helsinki, iMigaqo eLungileyo yoMzantsi Afrika

yokuSebenza eKliniki kunye neBhunga lezoPhando ngamaYeza (MRC) iMigaqo yeNqobo yezoPhando.

Simalunga nantoni esi sifundo sophando?

Oluphando lujongene nabantu abanolwazi ngamayeza esintu apha kulomhlaba wase Madwaleni. Simanyana amaGqirha, amaXhwele, iiNyanga, abaThandazeli, nabo bonke abantu abanyanga ngokwesiXhosa. Abantu abanyanga ngokwesiXhosa banolwazi kakhulu ngokwezempilo emphakathini. Iinjongo zoluphando zezoku phuhlisa olulwazi lwesiXhosa, ukuze sizoba nolwazi oluthe vetshe ngokwezempilo apha eMadwaleni.

Okwesibini, oluphando linenjongo zokuphuhlisa abantu abanyangayo ngokwesintu kulengingqi. Njengoko, kufanele ukuba sibuze ukuba ngobanina abantu abanyangayo apha eMadwaleni.

Kutheni umenyiwe ukuba uthathe inxaxheba?

Njengomntu onyanga ngokwesintu kulengingqi yaseMadwaleni, uyacelwa ukuba uthathe inxaxeba koluphando. Sineenjongo zokuba ulwazi lwakho ngokwezempilo zakwaXhosa luzakusinceda ekuphuhliseni ulwazi ngokunyanga ngesintu eMadwaleni.

Luyakuba yintoni uxanduva lwakho?

Ukuba uyavuma ukuthatha inxaxheba koluphando, uzakucelwa ukuba uzimanyane nabanye abantu abanyanga ngokwesiXhosa kwiintlangano ekuthiwa ziiFocus Group, apho sizobe sixoxa ngolwazi lozempilo. Kwezintlanganiso, ungakhetha ukuba uyafuna na ukuyiphendula imibuzo okanye awufuni. Awunyanzelekanga ukuba uphendulo imibuzo xa ungafuniyo.

Xa unqwenela ukuthetha nompandi yedwa, ungatsho. Nizohlangana nobabini kweyenu intlanganiso, bengekho abanye abantu. Ningahlangana endlwini yakho okanye apho usebenzela khona. Iingxoxo kwezindibano zizobhalwa ngumpandi, azigcine kwi tape recorder yakhe.

Kulentlanganiso, imibuzo ehlangene neenkcukacha zakho zizobuzwa. Nje ngegama lakho, ifani yakho, iminyaka yakho yokuzalwa, ubuhlanga bakho, neminyaka yakho usebenza ngokwezempilo. Imibuzo izoba:

- Umsebenzi wakho: Ingaphi iminyaka usebenza ngokwezempilo? Ngosuku, inoba ujongana nabaguli abangaphi?
- Imibono yakho kwezempilo: Yintoni impilo? Impilo ifumaneka njani ekhayeni nasemphakathini? Abantu abanyanga ngokwesintu badlala eyiphi inxaxheba ekugcineni impilo emphakathini?
- Ulwazi lwakho ngokwezempilo: Abantu abanyanga ngokwesintu banyanga eziphi izigulo nezifo? Bazinyanga njani? Basebenzisa eziphi izityalo namayeza?
- Ukuphuhlisa impilo ekuhlaleni: Wena ucinga ukuba singenza njani ukuhlanganisa ulwazi lwesingesi nolwazi lwesiXhosa kwezempilo apha emphakathini?

Ingaba uza kuzuza ekuthatheni inxaxheba kolu phando?

Oluphando luneenjongo zokuphuhlisa ulwazi lwesiXhosa kulengingqi. Ngokwenza njalo, sinenjogo zokunceda iinyangi zesintu ziphuhle nazo ngolulwazi lwabo.

Ingaba zikho iingozi ezibandakanyekayo ekuthatheni kwakho inxaxheba kolu phando?

Hayi, akukho ngozi kuwe ebandakanye noluphando.

Ukuba awuvumi ukuthatha inxaxheba, loluphi olunye unyango onalo?

Oluphando alijongananga nokunyanga mntu ngeyeza. Luphando olujongene nolwazi lwezempilo nabantu abanyangayo ngokwesiXhosa. Ukuba awuvumi ukuthatha inxaxheba, akhonto imbi izakwenzeka kuwe.

Ngubani uza kufumana ingxelo yakho yamayeza?

Ulwazi oluzakuphuma koluphando luzakubonwa yi Yunivesity yase Stellenbosch, lisebe likaRhulumente okuthiwa yiNational Research Foundation (NRF) olujongene nolwezophando lolwazi eMzantsi Afrika.

Kuza kwenzeka ntoni kwimeko yesiganeko esingalindekanga sokwenzakala ngenxa yokuthatha kwakho inxaxheba kwesi sifundo sophando?

Awuzonzakala ngokuzimanyana noluphando.

Ingaba uza kuhlawulwa ngokuthatha inxaxheba kwesi sifundo kwaye ingaba kukho iindleko ezibandakanyekayo?

Hayi awusayi kuhlawulwa ngokuthatha inxaxheba kwesi sifundo. Akusayi kubakho zindleko ezibandakanyelwa wena, ukuba uthatha inxaxheba.

Ingaba ikho enye into ekumele uyazi okanye uyenze?

Kumele wazise ugqirha wosapho okanye ugqirha oqhelekileyo nje ukuba uthatha inxaxheba kwisifundo sophando. (*sibandakanye ukuba sikhona*)
Ungaqhgamshelana noMphandi …**Thandokazi May** kule inombolo yomnxeba [redacted] ukuba unemibuzo engaphaya okanye uhlangabezana neengxaki.
Ungaqhagamshelana neKomiti yoPhando Lomntu kwa-021-938 9207 ukuba unenkxalabo okanye izikhalazo ezingasonjululwanga kakuhle ngugqirha wakho wesifundo.
Uza kufumana ikopi yolu lwazi kunye nefomu yemvumelwano ukwenzela iingxelo zakho.

Isifungo somthathi-nxaxheba

Ngokuytyikitya ngezantsi, Mna ……..…… ndiyavuma ukuthatha inxaxheba kwisifundo sophando semfuzo esibizwa ngokuba *(Ukuphonononga Nokuphawula iinyangi zesintu zaseMadwaleni Nobudlwelwane bazo Namachiza esintu Nezempilo)*
Ndazisa ukuba:

- Ndilufundile okanye ndalufunda olu lwazi kunye nefomu yemvumelwano kwaye ibhalwe ngolwimi endiliciko nendikhululekileyo kulo
- Bendinalo ithuba lokuba ndibuze imibuzo kwaye yonke imibuzo yam iphendulwe ngokwanelisayo.
- Ndiyakuqonda ukuba ukuthatha inxaxheba kolu phando kube **kukuzithandela kwam** kwaye andikhange ndinyanzelwe ukuba ndithathe inxaxheba.

- Ndingakhetha ukusishiya isifundo naninina kwaye andisayi kohlwaywa okanye uqal' ugwetywe nangayiphi indlela.
- Usenokucelwa ukuba usishiye isifundo phambi kokuba siphele, ukuba ugqirha wesifundo okanye umphandi ukubona kuyinzuzo kuwe, okanye ukuba andisilandeli isicwangciso sesifundo, ekuvunyelenwe ngaso.

Kutyikitywe e-(indawo) .....……..…….. ngo-(usuku) ……...……...

....

Umtyikityo womthathi-nxaxheba **Umtyikityo wengqina**

Isifungo somphandi

Mna *(igama)* …….. ndiyafunga ukuba:

- Ndilucacisile ulwazi olu kweli xwebhu ku-……..……...
- Ndimkhuthazile ukuba abuze imibuzo kwaye athathe ixesha elifanelekileyo ukuba ayiphendule.
- Ndiyaneliseka kukuba uyakuqonda ngokwanelisayo konke okumalunga nophando okuxoxwe ngasentla.
- Ndisebenzise/andisebenzisanga toliki. (*Ukuba itoliki isetyenzisiwe kumele ityikitye isaziso ngezantsi.*

Kutyikitywe e-(indawo) .....……..…….. ngo-(usuku) ……...……..

....

Umtyikityo womphandi **Umtyikityo wengqina**

Isifungo setoliki

Mna *(igama)* …….. ndazisa ukuba:

- Ndicende umphandi (*igama*) …… Ekucaciseni ulwazi olu lapha kweli xwebhu ku-(*igama lomthathi-nxaxheba*) …….. ndisebenzisa ulwimi lwesiAfrikaans/lwesiXhosa.
- Simkhuthazile ukuba abuze imibuzo kwaye athathe ixesha elifanelekileyo ukuba ayiphendule.
- Ndimxelele eyona nto iyiyo malunga nokunxulumene nam.
- Ndiyaneliseka kukuba umthathinkxaxheba ukuqonda ngokupheleleyo okuqulathwe loluxwebhu lwemvumelwano eyazisiweyo kwaye nemibuzo yakhe yonke iphendulwe ngokwanelisayo.

Kutyikitywe e-(*indawo*) .....…..…….. ngo-(*usuku*) ……..……..

....

Umtyikityo wetoliki **Umtyikityo wengqina**

Appendix C

Interviewing guide

During the interview, the researcher sat down with the participant in a comfortable private space. If the participant did not wish to answer any of the questions in the discussion, he/she may say so and the investigator will move on to the next question. The interview was conducted in the language that the participant felt comfortable with. The discussions and interviews were recorded by the investigator using a Dictaphone.

During the discussion and interview, some personal information were collected, such as gender, age, ethnicity and years of practice. Questions asked were about:

1. Your health/medical practice: How long have you been working as an indigenous healer? On average, how many patients do you see a day? What sort of ailments do you treat in your practice?
2. Your views on health care: What is health, and how is it achieved and maintained within the home and community? What is the role of healers in their communities when it comes to maintaining health?
3. Your experience with treating illness: What types of illness do indigenous healers treat? How do indigenous healers manage or treat illness? What herbs and plants do healers use to treat illness?
4. Potential improvement to health care in your community: In your opinion, in what way can indigenous healers and their knowledge of indigenous medicine be integrated into the current health care system in your community?

Appendix D: Mji (2013) findings on the illnesses managed by elite older Xhosa women in the home

Table 4.10: The health problems that older Xhosa women from Focus Group 3 manage at home

ealth roblem	Steps taken for diagnosis	Remedies	Management steps/ strategies	Changes - critical incidence	Rationale for giving up	Referral
Ikrwede aused by a peworm)	Vomiting and stomach cramps.	*Mafumbuka*	Grind raw; mix with water. Give 2 tablespoons, 3 times a day.	Uncontrolled diarrhoea.	Afraid of dehydration and losing energy.	Hospital – elite person.
Makrokro lood stools)	Diarrhoea with blood – stay in the bathroom without	*Mafumbuka* and seawater	Mix with seawater. (This is rejected by elite women. According to them	Stomach, feet and hands start to swell and diarrhoea does not stop.	Afraid of dehydration and losing energy.	Hospital – elite person.
3. *Isisu sokuntshintsha* (period pains)	Sometimes accompanied by period stains (droplets of blood coming out).	Conservative; sometimes take to special person; when cured one can conceive.	If given medication (*Misela*) danger of conceiving. Treat conservatively.	No critical incidence except danger of not conceiving if not treated.	Period pains continuing, this might decrease the chances of conceiving.	Take to a woman or traditional healer.
4. *Isisu samalaza* (stomach ache in a child caused by mother being outside the home)	Diarrhoea with sour milk-like stool.	Grass and dust from the intersection or *Ubuhlungu*.	Bring grass from the intersection. Wash child with water that has been rinsed in this grass.	Usually helps.	No need to give up.	No need to refer.
5. *Ijengezi* (first stool)	First black stool – all babies need to get rid of this stool.	*Isichakathi*	Boil in water and feed to child.	Dangerous if stool does not get out; can cause 'plate' or can go up the back and cause damage.	Problems in child's development – 'plate'.	Go to coloured person who knows about this type of medication .
6 *Ishimnca* (rash in children after birth)	First rash after birth.	*Usikhikhi, Ingxozela, Umthobhothi* .	Boil *sikhikhi* with water, cool and drink. Use leaves to make paste and smear on the child. *Ngxozela* – grind and smear. *Umthobhothi* – grind and smear. Or mix with water and give a teaspoon to child.	Usually clears – can cause ear problems.	Dealt with and sorted out at home.	No need for referral

Appendix E

Achievements of the study; a mini report

The study has achieved a significant amount of success from its beginning in 2017 and throughout its completion in 2018. The study was able to produce four (4) draft articles that will be submitted for publication to academic journals. One of the papers is currently undergoing an editorial review process at a major South African academic journal. The other 3 draft articles are still being improved by the investigator so that they can also undergo the review process.

Additionaly, the investigator was able to succesfuly assist the indigenous healers of Madwaleni to establish their own coalition of healers. The coalition has been formally recognized by the local Chief and the local Mbashe municipality. The coalition has been named as the **Makukhanye Traditional Healers of Mbash**e, and consists of an executive committee that has a Chairperson, Vice Chairperson, Secretary and Treasurer. In 2018 the coalition established and adopted a Constitution that details the Aims, Objectives and Code of Ethics for the group. The investigator helped the coalition to design an emblem that represent the group. A picture is shown below.

Secondarily, the investigator assisted the coalition by hosting an indigenous health conference in Hobeni village on 31 July 2018. The conference aimed to provide a space of healthy knowledge exchange between biomedicine and indigenous healers in the area of Madwaleni so as to improve the level of healthcare that can be provided for the indigenous patients of Madwaleni. Secondarily, it aimed to improve the relationship between the indigenous healers and the biomedical health

professionals in the area by providing spaces of healthy dialogue and discussion by lifting the veil of secrecy around health knowledge.

The conference objectives were to:

- Bring biomedical professionals and indigenous healers together to share and exchange health knowledge
- Provide biomedical assistance in TB and HIV prevention for indigenous healers
- Provide a building block as to how the indigenous healers of Madwaleni and health professionals could work together including the process and steps to be taken to improve the relationship.

Overview of conference:

This small conference hosted 40 indigenous healers from the various villages of Madwaleni. In attendance were amaGqirha (diviners), amaXhwele (herbalists), older elite women, older elite men, ababelekisi (birth attendants), amakhankatha (initiation nurses), abathandazeli (faith healers). The Chiefs of Hobeni and Nkanya, Chief Phathisile and Chief Ngubelanga were also present to offer support and to also engage in the conference. The biomedical professionals who provided the biomedical knowledge were provided by the Donald Woods Foundations - Sister Billi and Sister Mngunyana. Sister Billi has operated as a Senior Nurse Practitioner and Nursing trainer in Madwaleni for over 4 years. She is currently leading the training of Community Health Workers and clinic nurses in the area. Sister Mngunyana has worked in the biomedical field for most of her career. She has worked as a matron at a big public hospital in Port Alfred for many years. In Madwaleni, she facilitates the Women's Forum, Community Health Outreach Program as well as the training of Community Health Workers alongside Sister Billi. The Head of the 9 clinics in Madwaleni, Mr Will, sponsored the Healers in attendance in the conference with personal protective equipment (PPE) such as surgical gloves and condoms. He also promised that all the 9 clinics, as well as the hospital will from now on provide the healers of Madwaleni with clean PPE. The healers can collect these at request at the nearest clinic.

Summary of conference:

The first part of the conference was headed by Sister Mngunyana. She provided knowledge about TB- how it is spread, treated and how it can be prevented.

The second part of the conference was headed by Sister Billi. She provided knowledge about STIs and HIV/AIDS.

All biomedical health training materials were provided by the Donald Woods Foundation (DWF).

All healers who participated in the conference were provided with a certified training certificate that is endorsed by the Eastern Cape Department of Health as well as the DWF. (See training certificate below).

A way forward from the conference:

The conference provided a space for the indigenous healers of Madwalni to engage with biomedical professionals. It also allowed for the latter to lift the veil of secrecy around their Western knowledge. The indigenous healers appreciated this sentiment and have promised to also make firm steps on their side to lift the veil of secrecy around their indigenous knowledge. This serves as a strong step towards the reconciliation process between the two health systems in the area. Both the indigenous healers and the biomedical professionals have requested that a second conference be held, this time focusing on Diabetes, Hypertension and Cancer as these are the most common non-communicable diseases that both health system face in Madwaleni. A copy of the training certificate is shown below.

Province of the EASTERN CAPE HEALTH

Donald Woods foundation

Health Training in TB & HIV

This Certifies that

_____ (Name)

_____(ID No)

Attended a short course on

TB/HIV BASIC PUBLIC HEALTH TRAINING

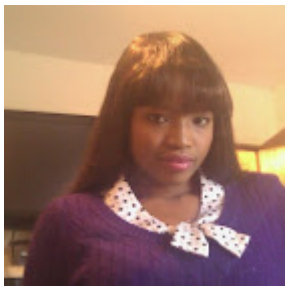
on _____31 July 2018_____

Key topics and modules: MDR/XDR TB infection; HIV and STI infection and prevention

_____

Signature: General Manager

The investigator participated in the 2nd International Conference on Clinical trial and Innovative Therapuetics 2018 held in Durban. She submitted a poster presentation and an abstract titled "A Catalogue and Description of the Indigenous Herbs of Madwaleni and the Ethnobotanical Environments in Which They Grow" for possible publication in the *Journal of Innovation & Research in Health Sciences and Biotechnology (JIRESH-Biotech)*. A copy of the Abstract is given below.



A Catalogue and Description of the Indigenous Herbs of Madwaleni and the Ethnobotanical Environments in Which They Grow.

Thandokazi May[1], Gubela Mji[2]

Many of the indigenous people throughout the Eastern Cape make use of the natural environment and all its resources. It is believed that the natural environment possesses the Divine spirit of God and the ancestors known as *umoya*, which is understood to be the vital life force that sustains all living things. Very often in academia, the deeper significance of natural resources is seldom probed and recorded. Hence, the primary aim of this paper was to describe the herbs used in Madwaleni and the ethnobotanical environments in which those herbs grow, and to additionally describe the relationship the amaBomvana people have with the natural environment.
The amaBomvana are greatly influenced by their natural environment, and both animals and plants play a supporting role in maintaining healthy relationships with the family and the ancestors. The ethnobotanical environment that exist in kwaBomvana carries a deep spiritual and cultural significance, and is a space of healing. People harvest resources from the forest and the family garden as a means of maintaining well-being. Medicine collected in the garden is prepared at home by a knowledgeable family elder, whereas medicine collected in the forest is either prepared at home or by a trusted indigenous healer in the community depending on the severity of the illness. The importance of natural resources lies in their usage in safeguarding the health and prosperity of the family unit, the community and animals.

Key words: Indigenous health practitioner; indigenous medicine; amaBomvana, ethnobotany; health; ethnomedicine;

Biography

Thandokazi May is an experienced multi-disciplinary junior biomedical scientist with a broad skill set in multiple fields of biomedicine; including Microbiology, Genetics, Biochemistry and Immunology. Her past research experience includes conducting studies at the University of Iowa's Carver College of Medicine, the Luther College Biology Department, and at the Stellenbosch University Immunology Research Group. Thando's academic and professional interests extend to Anthropology and Public Health. Outside of science, she is a well-traveled global citizen and an alum at the Semester At Sea international studies program. Apart from being a scientist, Thando is also a practitioner of indigenous medicine. She is currently an MSc student in Clinical Pharmacology at Stellenbosch University. It is her life goal to foster a partnership between biomedicine and indigenous medicine for the enhancement of the level of health care that can be available for all those who seek holistic and integrative care.

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Appendix F

Draft papers for publication emerging from the study

This section of the Appendices showcases the draft papers that have emerged from this study. This section will be presented in the format of 4 individual abstracts. Each paper serves to explore particular themes and sub-themes that have emerged from the research question. Each paper will be edited further for publication when a suitable journal call has been identified.

Paper 1:

The Indigenous Healers of Madwaleni and the Illnesses They Manage.

Abstract

Background: The WHO defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (Organization, 2017). Previous studies have shown that for the amaBomvana of the Madwaleni area of the Eastern Cape, health is attained through the maintenance of solid relationships between all members of society, the ancestors and the natural environment. When sickness results because of rifts in these relationships, medicine must be administered to treat the illness and to regain the normal state of health. The main aim and objectives of this article was to explore and identify the indigenous healers of Madwaleni including the illnesses these healers manage and the herbs they use to treat each illness.

Methodology: A descriptive, qualitative and ethnographic approach was used to document the lived experiences of 25 participants through engaging the participants in interviews and Focus Group Discussions. For this paper, 4 one-one-one interviews, and 8 Focus Group discussions were conducted. All participants were adults between the ages of 18 and 85 years, with all being trained indigenous health practitioners in various fields within indigenous medicine in Madwaleni. Other adults that have not undergone formal training to become indigenous healers through the laws of *ukuthwasa* also participated. For this paper, 9 males and 16 females participated.

Findings: Findings show that for the amaBomvana people of Madwaleni there are various groups of indigenous healers who manage and treat illness. These healers operate within a culturally established folk arena, comprising of the collective ancestral relationships in the community, family relations and the naturally occurring herbs and plants of KwaBomvana. Medicines and herbs must be able to heal mind, body and soul, and consequently, amaBomvana medicines have not only a healing function, but also have an apotropaic spiritually protective function (Dold & Cocks, 2012)

Conclusions: The health strategies of the amaBomvana are exceptional and have the potential to help unlock some of the modern medical challenges faced by biomedicine. The existence and endurance of various indigenous healers and their IHK strategies in the face of the threat of foreign religion, education and biomedicine is attestation to this. It is the investigator's recommendation that reconciliation first happen within the indigenous healing community itself as there exists unresolved tensions between indigenous health practitioners in Madwaleni due to differences in philosophy. A reconciliation process that takes the form of an exchange of IHK strategies between the various healers is recommended to achieve this.

Keywords: indigenous health knowledge; indigenous healers; indigenous medicine; reconciliation

Paper 2:

The Relationship between Indigenous Health Practitioners and Biomedical Health Professionals in Madwaleni.

Abstract

Background: There exists conflict between the indigenous health practitioners of Madwaleni and the biomedical health practitioners that operate in the area. This paper identifies the possible causes and reasons of this conflict and explores ways in which the conflict can be resolved. The main research question was in what ways the two health care systems in the area can be amalgamated in a mutually beneficial partnership.

Methodology: Both indigenous and biomedically trained health practitioners operating in Madwaleni participated in the investigation, with 15 indigenous healers and 5 biomedical professionals being interviewed in 2 Focus Group discussions with the healers, and 2 FGDs with the biomedical professionals, totalling to 4 FGDs for this paper. Meetings with the healers took place at the Donald Woods Foundation in the village of Hobeni, whereas meetings with the biomedically trained practitioners took place in the Nkanya and Hobeni clinics. A qualitative analysis of the historical and cultural factors that have shaped both health care systems in the area, including strategies they have used was performed.

Findings: This paper is proposing that the conflict between indigenous health professionals and biomedical professionals in Madwaleni started when the secondary hospital was built by in Dutch Reformed Church1960. The indigenous healers of the area claim they were never consulted by the Church, nor by the national government that consequently took over management of the hospital, in the introduction of allopathic medicine in the area. This division created a lack in the exchange of health knowledge in the community, resulting in a mistrust between indigenous and biomedical professionals, with biomedical professionals claiming their medical knowledge to be superior to indigenous medicine. This tension has negatively affected patients who seek to utilize both indigenous and biomedical health strategies to manage illness.

Conclusions: It is the recommendation of this study that spaces of reconciliation be established in Madwaleni to assist in building relationships between the indigenous health knowledge system and the biomedical health system. This reconciliation would help assist in providing patients of Madwaleni who are seeking to integrate biomedical health strategies with indigenous health strategies to manage illness with resolution and freedom of choice.

Keywords: Biomedicine; Indigenous medicine, Traditional Health Practitioners (THP); Reconciliation

Paper 3:

A Catalogue and Description of the Indigenous Herbs of Madwaleni and the Ethnobotanical Environments in Which They Grow.

Abstract

Background: Many of the indigenous people throughout the Eastern Cape make use of the natural environment and all its resources. It is believed that the natural environment possesses the Divine spirit of God and the ancestors known as *umoya*, which is understood to be the vital life force that sustains all living things. Very few studies have attempted to study the relationship indigenous South African people have with their natural environments. Very often, the deeper significance of these resources is seldom probed and recorded. Hence, the primary aim of this paper was to describe the herbs used in Madwaleni and the ethnobotanical environments in which those herbs grow, and to additionally describe the relationship the amaBomvana people have with the natural environment.

Methodology: This is a descriptive, qualitative and ethnographic study in which the experiences and indigenous knowledge of participants was explored in a diachronic manner. Participants, which included 2 royal chiefs and 14 indigenous health practitioners, took part in interviews and Focus Group Discussions. The chiefs were each interviewed once on separate occasions, and the healers participated in 3 FGDs. Photographs of the herbs they identified were taken using a Nikon camera. In total, the study population comprised of 4 males and 12 females between the ages of 18 and 85 years. A qualitative analysis of the data was performed.

Results: The amaBomvana are greatly influenced by their natural environment, and both animals and plants play a supporting role in maintaining healthy relationships with the family and the ancestors. The ethnobotanical environment that exist in kwaBomvana carries a deep spiritual and cultural significance, and is a space of healing. People harvest resources from the forest and the family garden as a means of maintaining well-being. Medicine collected in the garden is prepared at home by a knowledgeable family elder, whereas medicine collected in the forest is either prepared at home or by a trusted indigenous healer in the community depending on the severity of the illness.

Conclusions: The amaBomvana people of Madwaleni have an innate understanding of their natural environment. The importance of natural resources lies in their usage in safeguarding the health and prosperity of the family unit, family fields and animals. It is the recommendation of this study that more research be done into the relationships between the people, the plants, the animals, the ancestors and the rest of the natural environment in Madwaleni.

Key words

Indigenous health practitioner; indigenous medicine; amaBomvana, ethnobotany; health; ethnomedicine;

Paper 4:

The Journey of Becoming a Western Educated Female Indigenous Healer in Madwaleni

Abstract

Background: As a holder of both Western and indigenous knowledge, I was often rejected for being a biomedically trained indigenous health practitioner in Madwaleni. The reluctance to accept that these two knowledge systems can be practised side-by-side stems from the broken relationship between biomedicine and indigenous health knowledge in the area. Additionally, the indigenous knowledge system itself has disjuncture in its understandings of the intersections between gender, spirituality and power. This article serves to explore the challenges presented by my gender, spirituality and formal education while conducting research in Madwaleni.

Methodology: This is an ethnographic qualitative study in which I used the techniques of reflexivity and feminist research methods to present, describe and analyse my experiences and reactions during my study, in efforts to better understand the process of continuous learning. I made use of a reflective journal in my documentation. The data was resented in the form of 4 case studies which present certain themes and subthemes that emerged from the data.

Results: Within the indigenous healing practice itself, violence and abuse are prevalent and is rarely ever discussed**.** The introduction of a formally educated, young female indigenous healer challenged both male and female healers in Madwaleni to reflect on the patriarchal systems of power that have shaped amaBomvana society, and consequently their understanding of gender, spirituality and power within the realm of indigenous medicine. However, IKS has been a system that has been historically denied a platform to be recognized as a valid knowledge system by practitioners of Western knowledge systems, and consequently still needs to be acknowledged, reconciled and healed.

Conclusion: This study recommends that the exploration of the experiences of female healers can help us better understand the spiritually damaging nature of gender-based violence within an indigenous setting, and how we can fully achieve and apply female justice in indigenous communities.

Key words: Indigenous healers; IKS; education; gender;