

COMMUNITY KNOWLEDGE AND PERCEPTIONS TOWARDS THE USE OF
TRADITIONAL AND WESTERN MEDICAL SERVICE SYSTEMS IN COLIGNY
COMMUNITY IN THE NORTH WEST PROVINCE, SOUTH AFRICA

By

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DEDICATION

This study is dedicated to all the community knowledge holders and traditional health practitioners of Coligny community, in the North West Province, for making time to participate in this study. This study is also dedicated to my late brother Japhta Nthompe, and my late great grandmother Masekgome Francinah Hlabe who taught me everything I know and made me the woman I am today.

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LIST OF ACRONYMS

AIDS: Acquired Immuno-Deficiency Syndrome

DST: Department of Science and Technology

HIV: Human Immune Virus

IK: Indigenous Knowledge

IKS: Indigenous Knowledge Systems

NHS: National Healthcare System

NRF: National Research Fund

THM: Traditional Herbal Medicine

THPs: Traditional Health Practitioners

TM: Traditional Medicine

UNICEF: United Nations International Children's Emergency Fund

WHPs: Western Health Practitioners

WHO: World Health Organisation

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ABSTRACT

The research study used a qualitative approach to investigate community knowledge and perceptions towards the use of traditional and western medical service systems in the North West Province, with special reference to Coligny community. Qualitative research methods such as focus group discussions, in-depth interviews, direct and participatory observations, and questionnaires were utilized as the main methods for data collection. As such, the researcher was able to interact with traditional health practitioners, key IK holders, and the community at large.

In consultation with the community leaders and using a stratified random sampling procedure a sample of 30 respondents (10 males and 20 females) was selected for the study. It was composed of Traditional Health Practitioners (THPs) and other key Indigenous Knowledge (IK) holders. The study focused more on women THPs and key IK holders because they were the guardians of IKS with regard to the use of traditional medicine. They were knowledgeable about Traditional Medicine (TM) as health care providers to both their families and the community at large. Furthermore, the socio-economic and demographic characteristics of the research participants were collected and interpreted from their own cultural perspectives. These have cultural meanings and significance in the context of traditional medicine and healing practices in the community.

The study discovered that majority of the research participants in the study community depended TM for health care. The study also found out that the women THPs and IK holders had wide knowledge of TM pertaining to harvesting and processing of TM materials to ensure sustainable biodiversity of the medicinal plant species. The study community was characterised by limited modern medical and health care services. The study revealed that even though the community benefited from western medicine, it had a lot to offer in terms of knowledge of TM for public health care. This knowledge was mostly held by women. It needs to be documented to inform policy, ensure accessibility, and be shared with young generations for sustainability.

CHAPTER ONE

INTRODUCTION

1.1. Background

The uses of traditional and modern conventional medicine have always been in conflict with each other. Between these two systems, there existed major differences in how the world is viewed due to lack of cooperation and common understanding (Kangwa, 2010). Both the ideology of ethnocentrism and the impact of colonialism encouraged mistrust and dislike in the relationship, hence creating tension between these two medical systems (Kangwa, 2010). Ethnocentrism is a perspective that views one particular ethnic group as being superior to all others (Gollinick et al. 2010; Manning and Baruth, 2009; Ovando et al. 2006). Alternatively, colonialism is a practice of supremacy that involves the defeat of one people to another (Tetah, 2010).

The local community of Coligny in the North-West Province, South Africa is characterised by various contestations on the opportunities and limitations of the two medical and healing systems. A number of community members and other stakeholders have a belief that Traditional Medicine (TM) and healing practices are not scientifically proven and hence, it is not safe (Okulo, 2009). Nonetheless, Kangwa (2010) supports Okulo (2009) and states that there is a lack of trust and common understanding between traditional healing and western medicine, with the latter considered scientific and rational, while the former is considered spiritual and irrational. Furthermore, Western missionaries tend to associate African traditional healing with witchcraft or evil practices (Kangwa, 2010), which makes some community members lose faith and interest in its uses.

As a result of the above, everything to do with ancestors is considered evil, and this did not create a bond or an understanding between the people and the Traditional Healthcare Practitioners (THPs). Instead, there was no trust between the western and THPs as indigenous people had no faith in western medicine as it was not in line with what they believed to be the root cause of ailments. Western medicine considered the spiritual aspects and practices of indigenous people as evil and irrational (Woolley et al. 1997). This is in spite of the fact that traditional healers in the community provide most of the primary health care due to limited western medical services. Besides being associated with witchcraft, TM and practices in the community have been perceived with the following limitations which need to be empirically investigated: Firstly, TM is considered inappropriate for many disease conditions (Kolawole,

2001). It is argued that modern medicine treats unexpected and life-threatening illnesses and accidents much more successfully than TM and healing practices. For instance, a traditional healer is unable to treat serious psychological or physical problems. This includes a broken leg, and is also considered unable to effectively heal appendicitis or any heart related problems as efficiently as a western health care practitioners and western medical service facilities or treatments and analysis such tests, operations, and treatments. Secondly, lack of dosage instructions could lead to the risk of overdosing Kasilo (2003). Thirdly, there is a threat of harming one's life when herbs are harvested in the wild. This is because one might collect the wrong herb or use the wrong part of the plant. Finally, lack of regulation as herbal products are not securely controlled, patients do face the danger of purchasing medicinal products that are of low quality (Kasilo et al. 2010). This is attributed to the fact that the quality of herbal products may differ among collections, crops or producers. As a result, recommending the suitable dosage of TM is viewed as a challenge.

However, besides limited modern medical services, most community members in Coligny still have a strong faith in TM. This is due to the following factors: traditional medical products have reduced risk of side effects (Whitehead, 2003). They have the view that most TMs in the form of herbs are more accepted by both the community knowledge holders, consumers and patients, with fewer unplanned concerns than the western medicines. Also, they have experienced that TMs, that is, traditional medicinal herbs usually are more efficient for on-going health problems which are not treated using western medicine. The strength of TM is that it is less expensive (WHO, 1995). TMs are more affordable than western medicines. They are widely available and can be accessed without a recommendation as one can simply obtain it from the fields or bushes for self-healing (WHO, 1988). Furthermore, one can grow some simple traditional medicinal plants, such as peppermint at home (Mwangi, 2000). It is on the basis of these contestations that the study aims to conduct an empirical investigation on the community regarding their knowledge and perceptions on the use of traditional and western medical service systems.

1.2. Problem Statement

As already mentioned on the background there are divergent views in the Coligny community with regard to the efficacy of TM as a primary health care system in a community characterised by limited modern medical services. There are community members and other stakeholders who look at TM and practices as not scientifically proven and hence not safe. TMs are often

associated with witchcraft which makes some community members lose faith and interest in their efficacy. However, others use these TMs and consider them more appropriate than western pharmaceutical products. They are accessible and affordable. These different perceptions have not been empirically researched to inform policy and further research, especially from the perspective of the community members of Coligny themselves. However, TM and healing systems seem to be dying out in many traditional communities especially Coligny community. The survival of TM and healing systems is thus a challenge.

1.2.1. Objectives of the Study

- To investigate the types of traditional and conventional medical services that exists in the Coligny community
- To examine the knowledge of the community members of Coligny towards the use of the medical service systems
- To examine the perceptions of the community members in Coligny towards the two types of medical service systems;
- To establish the contemporary prospects and challenges of the two types of medical service systems in the Coligny community
- To investigate the policy implications of the two types of medical service systems in the Coligny community.

1.2.2. Rationale and significance of the study

The motivation to undertake this study was triggered by the fact that I originate from the study Community (Coligny). I have grown up to experience the paradoxical situation that in spite of the fact that most community members expressed negative attitudes towards African TM; they still use them due to limited and poor conventional western medicinal services. The study findings will have a number of contributions: (i) they will provide an example of local community members' perceptions towards traditional and conventional medical service systems; (ii) will assist both the public and private sectors, including the Department of Health, to understand the contemporary challenges and prospects creating synergies between traditional and conventional medical services, especially in a rural setting hence help to develop appropriate policy strategies for interfacing the two medical service systems; (iii) the

information will provide the basis for future research activities on the two medical service systems.

1.2.3. Research Setting

The community of Coligny falls under Ditsobotla Local Municipality in the North-West Province. It is a small, poor rural community characterised by poor social services including medical services. People use both African traditional and conventional medical services. The community is composed of about 60 households. The majority of them (60%) being female-headed due to male migrant labour. The main activity is subsistence farming. The industries include cement factories such as Monsanto and Transnet, and various food production plants. There is a high rate of unemployment, with an estimated percentage of about 42.5 among the youth in Coligny. The most important natural resources are the soil and the underground and surface waters sources. The future of this area depends on keeping these resources clean and not overused.

1.2.4. Organisation of the Study

Chapter one: provides the following sections: background, rationale, problem statement, and objectives of the study.

Chapter Two: is the Literature Review and Theoretical Framework informing the study

Chapter Three: is the methodology of the study

Chapter Four and Five: presents the findings and discussions of the study

Chapter Six: provides the conclusion and recommendations.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

This section explored the existing literature addressing the key divergent Western and African theoretical perspectives on the uses of traditional and conventional medical services. A review of literature conducted relating to the concepts of traditional and western medical services reflect fundamental differences. Studies on the use of traditional and conventional medical services are not only philosophical and cultural in nature, but are technical as well. Consequently, a substantive agreement with the distinctions between different contexts, and the diverse debates related to their technical implications and conceptualisation are beyond the scope of this study. Accordingly, this section of the literature review focused on defining the concepts of traditional and conventional medical services; and outlined the critical issues that Western and African, especially South African researchers and theorists have highlighted and added to the debate on the uses of the two systems of medical services in African local communities. Emphases on the critical areas of contestation were outlined as they apply to the subject of this research.

2.1. Western and Traditional Medicine Defined

Western medicine refers to the treatment of all the medical ailments performed by western medical practitioners. These western medical practitioners include the nurses, psychologists, doctors, physicians and other health practitioners. They use western medical methods such as X-rays, radiation, theatres and other scientific methods. It is the type of medical system that heavily relies on scientifically validated products, and is evidence-based (Gbdossou et al. 2005). Conversely, TM is the type of medicinal treatment that is predominantly easily reached in rural communities. It involves herbal medicinal plants, spiritual healing, as well as acupuncture, which people use to cure fatal diseases. It also involves the interaction of the traditional healers such as diviners, herbalists or inyangas and the ancestors to heal the sick (WHO, 2002).

2.2. Western Views on Traditional Medicine

Most of the views on TM are based on the dominance of western knowledge in South Africa. Those in favour of TM and healing practices are founded on African Indigenous Knowledge and value systems. It is on the basis of these contrasting views that the literature review and

interrogates these divergent views associated with TM and healing practices. According to Green (1994:20), Indigenous Knowledge Systems (IKS) can be defined as;

that body of accumulated wisdom that has evolved from years of experience, trial and error as well as problem solving by groups of people working together to meet the challenges they face in their local environments, drawing upon the resources they have at hand.

This indigenous knowledge has been, for many years, transferred between generations through people's historical experience, way of life, social attitudes, behaviours and ethics (Lawset al. 1995; Springfield et al. 2005).

The discussion will start with the different contestations of IK as a knowledge system. Indigenous Knowledge as a knowledge system is still valued by those in communities devoid of western modern services and health care. In the absence of the culture of writing this knowledge, it is the type of knowledge that is verbally communicated and passed on from the elderly to the younger generation. It involves the skills and knowledge to identify and use herbal or traditional medicinal plants for specific illnesses. However, its uses and efficacy has been questioned by western scientists and medical health practitioners. They argue that TMs need to be tested and re-examined before they could be handed out to those seeking medical care (Clement 2006). This is because THPs are said to be not licensed or certified to provide people with medical services.

Furthermore, THPs are often accused of exaggerating their capabilities to heal diseases that are fatal, such as malaria and tuberculosis. They are said to be deceiving their patients into thinking that western medicine is too expensive and only temporarily cure these diseases. This is because the THPs' are said to only focus is to generate income (Sample, 2009). Hence, western medical practitioners, scientists and policy makers deny and dislike the idea of traditional healing. This makes it difficult for the TM to be accepted and included in the NHS of Africa (Okulo, 2009).

There are some limitations and challenges that African traditional medicines and THPs face in their respective communities. Amongst those challenges is the fact that the modern medical practitioners dislike and criticise this system of medical care. They still maintain that African Traditional Medicine (ATM) lacks scientific examination or is not scientifically proven and hence has not been closely reviewed and supported by the research findings (Okulo, 2009). Kasilo (2003) also argues that the weakness of traditional medicines is that they lack sufficient information about its safety to be used or consumed by people, that it is not evidence based. Its

effectiveness and quality of the products being given to the patients is also questioned. For these reasons, TM needs to be tested for its effectiveness and safety before the THPs can give the medicinal or healing plants to their patients (Clement, 2006). Again, it is argued that the manufacturing of TM is not carefully tested nor controlled, for healing purposes (Kasiloet al. 2010).

Moreover, Whitehead (2003) posits that TM has not been scientifically proven as modern medicine. At the same time, the scientific existence of this traditional healing is seen as being insignificant due to its vague work of art and inconsistency of the products. TM and its healing practices are not taken into consideration at all as one of the healing systems in the country. Furthermore, it is denied, and further being disrespected by both the policy makers and modern health practitioners. This makes it if not completely, almost impossible to be included into NHS (Chatora, 2003).

Contrariwise, Sambo (2003) argues that TM is not sensibly recognised due to its preparation methods, and hence cannot be included into NHS in Africa. As a result, the manner in which TM has been prepared by THPs is considered inappropriate (Kasiloet al. 2010). This is because most THPs used unhealthy techniques when preparing and managing herbal medicines (Selby, 2009). It has however been argued that the inclusion of TM and healing practices into National Healthcare System (NHS) by policy makers is too difficult. This is because the research methodologies and its assessment to determine its effectiveness and safety is way more difficult than those of the modern medicine (Sambo, 2003).

Sambo (2003) agrees that there is a lack of certified guiding principles of the TM and further argues that TMs lack regulatory and legal procedures for its practice. On the one hand, Miller (2000) suggest that what TM lacks and needs so as to be included in the (NHS) is consistent regulation whereby each ingredient in a single herbal plant is identifiable, and that all sets of herbs made in one plant is the same amount of the active ingredient. TM does not have a reliable way of preparation, the amount of medicine to take and how long, how to mix it, the dosage and the suitable storage of the concoction (Adjei et al. 2003).

Nonetheless, because TM does not have written instructions on traditional medicinal products, patients may consume or use a large amount of that product or even less than they should. Due to the difficulty of the traditional medicinal herbs, it is important that these herbs go through a serious testing and evaluation in the same way as the western medicines so as to confirm and ensure its safety, value and quality before they can be utilised by patients (Kasilo et al. 2010).

The latter authors also state that TM is said to be not recognised in the NHS, as it is seen to lack the necessary skills, because THPs are not licensed or certified as health care providers. The THPs' knowledge of disease and healing is said to lack the guidelines on whether TM can be utilised with other prescribed medicines like western medicines. It is said to have no indications of whether it is effective or not, because of its lack of scientific validations (Lewis, 2009). There is a confusion as to whether these traditional herbal products should be used or consumed the same way as food, dietary supplements or important food. This is because it lacks the necessary expertise and skills (Kasilo et al. 2010).

This is said to contribute to the difficulty in giving a name to TMs, and can cause a lot of confusion to patients and consumers. As mentioned earlier, THPs lack the necessary expertise. This may cause some of the herbal or healing medicinal plants to be polluted with deadly risky substances. It can also be misidentified, people using it may overdose, and it can get contaminated or wrongly labelled. Also, TMs can get misused by the THPs and patients may use it with other medications when they are not supposed to. This does not happen in western health care services as the required skills are provided (Kasilo et al. 2010).

2.3. Traditional Medicine and Healing in the Context of Indigenous Knowledge Systems

WHO (2002) states that traditional medical service system has been, for many years seen as inadequate, primitive, and not good for health sustenance. It is said to be even promoting poor health, and also to be not scientifically proven. As a result, THPs have lost the trust and faith of their local communities. This is because the majority of the people are focusing on the modern-oriented systems of healing and health care systems.

Nevertheless, WHO (1978) argues that traditional healing and its health care systems have been replaced by western healing and health care systems caused by colonisation in South Africa, and Botswana amongst others. For instance, the African way of life, such as worshipping, healing, religions, tradition and customs were discouraged from being practiced. Indigenous people were convinced that their way of living was not a proper way. As colonisers introduced their ways of living, their new traditions and customs, and ways of worshipping and new religion, indigenous people had to adapt with the changing times and environment. Hence, traditional or indigenous religions, traditions, knowledge and healing and health care service systems are being slowly, if not completely abandoned.

Traditional healing and health care service systems are more accessible in the rural than in the urban areas. Again, western healing and health care service system is only available in the

urban, as it is where most medical centres are located. This is the reason why many people in rural communities living with incurable diseases such as HIV and AIDS utilize traditional medicines. This is done to be able to manage some other diseases or infections that come along with it. It because of the greater accessibility of traditional healers, and confidence in their ability to manage these incurable diseases (WHO, 1988).

Moreover, WHO (1995) states that, THPs are well-known in their respective communities for their services and expertise in the health care system and the prevention of sexually transmitted infections. At the same time, TM is often rooted in wider belief systems and continues to be a crucial part in the livelihood of the people in rural communities.

2.4. Indigenous Knowledge Systems and Traditional Medical Practices

Traditional or indigenous knowledge exist in every country around the world. Its existence is mainly more to do with relieving both animals and human beings from their illnesses. This is because the THPs and their herbal concoctions made from herbal plants play a major role in healing millions of sick people around the world. Traditional or indigenous knowledge is one way of how people view the world, or how culture is understood. It is a belief of the Anthropologists that culture guides human behaviour, and affects the health and well-being of the people (Bodeker, 2001). They believe that in traditional rural communities, the importance of culture is to create and spread the significant knowledge, practices, and believes concerning the use of locally available natural resources to heal and ensure nutritional well-being of the people. Again, in these traditional rural communities, illnesses caused by evil spirits can only be healed by the THPs and their communication with the ancestors (WHO, 2002).

The people in rural setting, with the knowledge they have, are able to go to the bushes and find a specific medicinal plant they need at that particular point in time. They use it to heal themselves before they can consult either a traditional or western health practitioner (Mwangi, 2000). This knowledge has helped many generations. For instance, western health care facilities are not available in the traditional rural communities, where the people can easily access medical attention whenever they are in need.

As a result of the indigenous or local knowledge that indigenous people in rural areas have, several medicinal plants have been recognised all over Africa. This is because of being effective and good to cure several diseases that afflict communities. These medicinal plants include, for instance, *securidaca Longepedunculata*. The bark of this medicinal plant is dried up and used to cure nervous system disorders, while its dried leaves are used to heal sores,

wounds, coughs and snake bites. In Ghana, the root bark of this medicinal plant is used for those who have epilepsy (Mwangi, 2000).

People in rural areas heavily rely on the spiritual and practical skills of the THPs to provide them with remedies that will heal their ailments. These THPs have a unique knowledge of medicinal plants, their conservation and scarcity that are considered priceless. Usually the gathering of medicinal plants was allowed to be done by only the THPs or their learners (Bodeker, 2001).

Local people and their traditional knowledge have been experiencing social exclusion as they were, and still are, not included in the development processes or health related initiatives. This is where the inefficacy of indigenous knowledge and its healing come in. The local people, their history, knowledge, skills and values where, hence, not regarded as important (Kangwa, 2010). THPs and local community members who still valued traditional healing and its belief systems and Indigenous Knowledge, were considered to be backward, uncivilised and illiterate (Kolawole, 2001).

Even though Indigenous Knowledge (IK) is still under-utilised by the people, it is not as excluded as it was in the past. It is now used in sustainable developmental initiatives including health care systems. For instance, Indigenous Knowledge Systems (IKS) have been used in many other countries including South African healthcare for those who are victims of HIV and AIDS (Bodeker et al. 2001; Marco 2002). However, the use of TM has faced a number of criticisms from western perspectives.

2.5. Biomedicine or Western Medicine

Gbdossou and others (2005) suggest that western medicine is often compared with the methods used by THPs to heal the sick. Western medicine is usually focused on healing the diseases of the physical body only. Its main belief is based completely on scientific methods and skills as well as scientific medical laboratory analysis. Western medicine can be defined as a medical service system whereby western health care practitioners such as nurses, pharmacists, and surgeons treat symptoms and diseases using drugs, radiation, or surgeries. For the people to be well informed about their health related problems, and for those people to have a positive mind set or attitude towards their own health, correct information needs to be sent to the relevant messenger. For many African people in Southern Africa, especially those in the rural communities, the most trusted person is still the THP (also known as the *Sangoma* or *Inyanga*). For example, in Malawi, Lesotho, South Africa, Zimbabwe, among other countries, most

people associate TM with the herbal medicinal plants (also known as *Mishonga*) and wisdom from the THPs with significant spiritual healing.

Today, western medicine is seen as the most important medical service system and has been accepted around the world and as the preferred method of curing diseases. People around the world are not ashamed to talk about medical doctors and their medicines as they are about the TM, practices, and its health care practitioners. The western medical service system is able to identify and treat the physical and psychological diseases. However, the western medical services and its health care practitioners still do not know the causes of many diseases (Turton et al. 1993).

In western medical service and health systems, the diagnosis and treatment of diseases involves dealing only with the symptoms of the diseases. As a result, one has to keep taking treatment for the rest of their lives to prevent the recurring of the illness. This means that one has to live with whatever unbearable pain from physical and mental illnesses they may encounter, coupled with the side effects from the treatment.

The goal of the western medical service system is to ensure that useful methods are applied to remove the source of the diseases, thus promoting good health for the people. Its main aim is on the disease and the process of getting rid of it. According to many Africans, western medicine has not replaced African traditional healing. Winnicott (1990) however maintains that the methods of western health care systems and its practitioners would affect and change the people's healing system as traditional healthcare system would be abandoned.

Many people, including Africans, think that a western health care practitioner's decision about their health, through the use of high technological diagnostic machines and many tests conducted in laboratories, is the most informed, safe and sensible healing decision that has ever been available to human beings in the history of the world (WHO, 1978).

Instead, people utilize herbal medicine and healing practices because they have actually become afraid to see a western health care practitioner or go to the hospital. This is not only because of the inability of western medicine to solve their health problems that is involved, but also because of the high statistics of accidental deaths caused by the western health practitioners and their bad behaviours and incompetence (Whitehead, 1995).

2.6. African Traditional Medicine

Helwig (2009) defines traditional African medicine as an impartial and well-known healing system that involves the use of traditional herbal medicines and African spiritual healing. It is performed by traditional midwives, herbalists, inyangas, and diviners. THPs are said to be able to cure diseases such as the urinary tract infections, fever, anxiety, wounds and burns, gout, high blood pressure, diabetes, cholera and depression amongst others. They do this through the use of traditional herbs or medicinal plants. For treatment to be prescribed to the patient, firstly the illness has to be identified to use the relevant healing or medicinal herbs, which do not only heal but has a symbolic and spiritual impact.

The African concept of health and disease is associated with human driving forces such as the ancestors, God, enemies, witches and spirits and the physical driving forces such as the food we eat, the sun, dust and rain (Gbdossou et al. 2005). THPs produce their own herbal medications and have their unique ways of healing, through the spiritual guidance from the ancestors.

This guidance helps these THPs to utilize supernatural treatment strategies to learn the physical, social, and spiritual conditions of the patient. Majority of the people in rural communities use and believe in TM and healing practices.

Consequently, they use community knowledge holders; THPs, Traditional Birth Attendants (TBA) and faith healers. These TBA and faith healers use the power of prayer and water that is being prayed for, usually known as holy water, while the THPs combine prayer, holy water and TM and healing practices. TM and healing practices have been known and practiced for many decades in South African countries (Morris, 2001).

African people using traditional African medicine have a belief that illness is caused by the person not having balance in his or her social and spiritual well-being. It is believed that the person's spiritual well-being influences one's social well-being, that is, if a person is not well spiritually, they cannot be well socially or even emotionally. This type of medical service differs greatly from the western medical service, which only looks at the physical well-being of the patient. The western medical services are mostly accessed by those individuals who are financially stable enough to afford it and those that live in the urban areas where the medical centres are located. This means that the African rural dwellers who cannot afford the western medical service are unable to access it. Thus, African traditional medical services remain their only way of medical assistance. Traditional medical and health care system is a system based

on societal and cultural perceptions of health and diseases (Morris, 2001). It is still what 80% of the African people in rural communities rely on for health care services (WHO, 2002).

Gbdossou and colleagues (2005) further point out that TM and healing practices are slowly being recognised. This puts pressure on those who view western medicine as the only rational medical health care service system. For instance, more people are being informed about organisations that promote and represent THPs. These organisations include the Zimbabwe National Traditional Healers Association, the Southern African Traditional Healers Council, as well as the Association of THPs of Southern Africa. The author further alludes that African governments have come to realise and understand that THPs are the major health care givers for majority of the people in rural communities. They have also learnt that TM and healing practices are the preferred sources of health care.

Traditional medical service system, whether in America, India or Africa, have been used for many years, before the western medical service system came to existence. Each of these medical service systems, perform their healing practices differently. They have created their own methods of healing, and made use of what was locally available to them (WHO, 2002). The main aim of TM is not to look at only one specific health problem in one's body but to strike a balance in the human system. This is to ensure that the system's way of healing itself can maintain health. The healing of the disease is not difficult once this balance has been achieved (Simwaka, 2007). All this is done through the personal contact between the THP and the patient, whereby THP gathers information of the patient, through this contact, without the use of any kind of technology (Struthers et al. 2002).

2.7. Traditional Health Practitioners

The World Health Organisation (WHO) (2002) suggests that THPs can be referred to as the people that are seen by the people around them and the community at large as anyone who has the ability to provide medical health care services through traditional healing that involves the use of animals and mineral substances, herbal medicinal plants and other healing methods that are based on the social, cultural and religious backgrounds and existing knowledge, and belief systems involving the physical, social, spiritual and mental well-being, as well as other causes of the disease.

Furthermore, the WHO (2002) continues to state that, THPs are different from one another. They use different healing methods, use different medicinal plants, have different way of diagnosis. Hence, they fall under different categories. They are known all over South Africa

with different names by various ethnic groups and cultures. For example, in a Xhosa cultural society, they are known by the name *Amagqira*, while known as *Ngaka* in a Tswana and Sotho cultural society. Furthermore, in a Zulu and Tsonga cultural setting, THPs are known as *Mungome*, while the rest of the people in South Africa know them as *Sangomas*, from the word *Izangoma*, which is a Zulu word.

They are respected members of their respective communities demonstrating more than one skill. Their leadership and medical services play an important role in the health of the people. For instance, they resolve family disputes, marriages, sexuality, identity, infertility and general guidance of the children. This is because they have more indigenous knowledge than any other members of the community. Many people in communities still seek the advice of the THPs, and this advice is believed and acted upon by majority of the people in the rural communities (Simwaka, 2007).

2.8. Primary Health Care System

Turton and Orr (1993) suggest that primary health care system may be perceived as the first direction that one takes for health care service system. It is close to where people live and work. It is mostly known to be provided for by the western medical health care practitioners such as the nurses, health visitors in public hospitals and general health practitioners. The authors further state that primary health care system comprises of scientifically validated, socially accepted and realistic methods available to people and their families in their communities through their participation.

Primary health care system is an important health care system that involves medicines that are tested in laboratories for the safety of the people. Its ways of diagnosis and treatment are accepted in communities, its medical know-how is available to everyone. It is also reasonably priced to financially accommodate everyone, that is, the communities and the country at large. WHO and United Nations Children's Fund (UNICEF) (1978) state that primary health care system is not only important for the economic and social development of the community alone, but for the development of the country at large.

2.9. The Concept and Philosophy of Traditional Medicine

WHO (2002) defines TM as the complete knowledge and healing practices, whether medically validated or not, used to identify and prevent and heal one's physical, mental, social, spiritual imbalance, through rational healing depending completely on the logical experiences, skills,

observations and knowledge that is transferred orally or in writing from one generation to the other.

Disease is perceived and dealt with differently for both traditional and western medical health care service systems. Simwaka (2007) argues that when comparing traditional and western medicine, one should take note that western medicine is more involved in emergency medicine, with the main focus on trauma, care and rehabilitation for serious health problems. In contrast, TM is more based on the belief that, for a person to be considered healthy, they have to be mentally, physically, socially and spiritually well, through the use of the resources around you; the spirit and the use of one's mind (Struthers et al. 2002). The THPs use all of these in a well thought-out way to put together a specific health system. The important objective being to reinstate the patient to a harmonious relationship with oneself and the community. This way, every aspect of an individual's total well-being is taken into consideration and well treated.

Whitehead (1995) suggests that, because of such method, TM is much broader because it involves identifying the influence of the environment outside the individual as being involved in causing the illness. On the other hand, western medical service system only looks at the physical well-being. In this case, the physical condition of the patient becomes the main focus, with little or no consideration at all of the social and spiritual wellness of the patient. It is because of this difference in the healing methods of these two medical service systems that the traditional and western health care practitioners have difficulties in accepting each other's method of healing. As a result, there exists a clash of diagnosis and treatment methods as these two medical service systems view the world differently.

The African Medical and Research Foundation (2010) suggests that more than 60% of South African rural dwellers get their medical advice and healing from the THPs before consulting the western health care practitioners. Madamombe (2006) agrees and states that TM and health care service systems are mostly dependent on due to lack of or limited efficient western medical service systems. Nonetheless, the Institute of Environmental Science and Research (2009) points out that WHO estimates that, just about 80% of the people in rural communities depend heavily on the use of TM and healing practices for medical health care services.

However, western medicine has been perceived as the only sensible and consistent healing process towards progress and truth. For some time, African people have forgotten their culture, and the fact that western medicine is new, and that what they perceived to be 'alternative healing' is part of the African culture that has been practiced for a long period of time by our

forefathers. The ironic part about this is the true 'alternative' is this modern western medicine which comes with a total deviation in healing the world has ever known (Whitehead, 1995).

2.10. Conceptual Framework

The study is theoretically and methodologically guided by Afrocentricity as a conceptual framework within the context of African indigenous ways of knowing, knowledge production and value systems. Chukwuokolo (2010) asserts that during the period of colonisation, African indigenous ways of knowing, knowledge production and value systems were politically, economically, psychologically, and culturally marginalised. This included African traditional medical and healing practices. This was due to the European colonial socio-political domination, and economic exploitation of the African people. As a result, the European colonisers imposed their own belief systems and medical practices. This brings the debate on Eurocentricism and Afrocentricity. In the context of this study, Eurocentricism refers to the practice, conscious or otherwise, of placing emphasis on European (and, generally, Western) concerns, culture and values at the expense of those of other cultures (Onyewnenyi, 1993).

Afrocentricity is a theory that emerged in the early 1980s in the United States within the academic context of African-American studies. It was articulated by Molefi Kete Asante, in the 1980s and 1990s. Like most theories, it has come to be associated with different thrusts. However, at its core, Afrocentricity is a theory concerned with African epistemological relevance, also referred to as centeredness or location. Its ultimate goal is the liberation of African people from the grips of Eurocentrism. The primary and indispensable mechanism to achieve this goal is the fostering of African intellectual agency.

According to Asante (1990; 1993; 1998; 2003; 2007), Afrocentricity addresses the actions of the African people in their specific natural, cultural including spiritual environment, when responding to certain life occurrences such as diseases and other disasters. In the context of African TM and healing systems, it explains the importance of promoting African indigenous healing systems which were marginalised by colonial domination and Eurocentrism. A large proportion of African people, especially in the rural areas such as the study area (Coligny), depend on these traditional medical and healing systems for survival in the absence or limited western medical health services.

According to Afrocentricism, African life is both physical and spiritual. Eurocentrism tends to neglect the spiritual aspect of human life. Therefore, knowledge produced in an Afrocentric study and approach has to reveal the symbiotic relationship between the spiritual and physical

in human life. This implies that the value systems included in the research methods used in an Afrocentric study have to be controlled by the African experience. This can only be achieved through the interaction between the researcher and the knowledge holders and practitioners in the specific African community. In the context of this study, Afrocentricity believes that even though uneducated in the Eurocentric explanation, African THPs have an exceptional knowledge of the different types of herbs for healing purposes, the interactions among the human beings and the herbal medicine, their scarcity, which is considered incalculable (Kolawole, 2001).

African traditional leaders are able to produce their own concoctions and provide health solutions, by the assistance or guidance of the ancestors. The medicinal herbs produced by the THPs do not only heal but have a symbolic and spiritual significance (Morris, 2001). TM is associated with the belief that one has to balance their spiritual, social, physical, psychological well-being to be considered healthy (Struthers et al. 2002).

Nonetheless, in TM the spiritual aspects of life which tends to be neglected in western conventional medicine play a major role for healing purposes. In most rural settings of the world the spiritual and practical skills of the THPs are dependent upon so as to provide remedies that will heal ailments. This guidance helps in the use of supernatural and somatic treatment tools so as to learn the physical, social, spiritual conditions of the patient (Morris, 2001).

The THP uses all of these in an organised way to build a specific health system. Focusing on meta-physical causes such as unhappy gods or ancestors, spirits and obvious disease, healers practice a holistic approach – the main aim being to restore the individual to a harmonious relationship with the social order (Zou, 2008).

The study is of the view that, western medicine differs from traditional medicine and healing practices. For instance, their diagnosis, treatment, and belief systems are different. However, both have a significant role to play in the provision of public healthcare. Furthermore, each of these medical service systems has its strengths and limitations. Therefore, the study is of the opinion that, the interface of the two healthcare systems could be very beneficial for improved public healthcare. They need to learn from each other for improved and accessible services.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGIES

This section describes the overall methodology and methods used in the execution of the study. It describes its research setting and research design. The validity as well as the limitations of the study is also highlighted. Finally, it explains the ethical considerations that were put into perspective in conducting the study. The study will be mostly qualitative, with the use of data collection methods such as includes face-to-face interviews, questionnaires, participant observations, and focus group discussions.

3.1. Research Setting

The community of Coligny falls under Ditsobotla Local Municipality in the North-West Province. It is a small, poor rural community characterised by poor social services including medical services. People use both African traditional and conventional medical services. The community is composed of about 60 households. The majority of them (60%) being female-headed due to male migrant labour. The main activity is subsistence farming. Industries in Coligny include cement factories, like Monsanto and Transnet, and various food production plants. There is a high rate of unemployment, with an estimated percentage of about 42.5 among the youth in Coligny. The most important natural resources are the soil and the underground and surface water sources. The future of this area depends on keeping these resources clean and not overused.

3.2. Study Sample and Selection Procedures

In consultation with the community leaders and using a stratified random sampling procedure, a sample of 30 respondents (10 males and 20 females) was selected for the study.

Lindlof et al. (2002) describe stratified sample as a likelihood sampling procedure whereby the researcher splits the people or residents of focus into different smaller groups and then unsystematically chooses the ultimate topic consistently from the diverse sections. This sampling procedure is very useful when the researcher's aim is to focus on the particular smaller groups in the residents' Polit, and Hungler (1997), that is, the male and female community members.

3.3. Data Collection Process

In order to examine the Coligny community members' knowledge and perceptions towards the use of traditional and conventional medical service systems, the research study was conducted over a period of three months.

Taking into consideration the community-based and holistic nature of indigenous knowledge systems, the study was mostly qualitative. A qualitative research method was used because it is more flexible and interactive. It gave the researcher the opportunity to interact with the community members, and since I come from the area, I knew the language and culture of the community. Moreover, a qualitative approach is richer in information compared to a quantitative approach because it enabled the researcher to interact with the community. This was done through qualitative research methods such as focus group discussions, in-depth interviews, and participant observation. This approach was more relevant to a rural setting such as Coligny where most of the knowledge was transmitted orally. Therefore, I needed to interact with the community members to be able to extract thick data that would answer the key research questions.

Interviews

There were interviews between the researcher and the local participants such as the elderly, THPs, the western or conventional medical practitioners, the youth, and other local members of the community. Face-to-face interviews were used in the study while using tape recorders and audios to keep record of the conversations between the researcher and the respondents. These interviews, especially taking into consideration the secrecy and sensitivity of THPs when it comes to sharing their knowledge were privately conducted. This means, that the researcher visited the THPs and other community knowledge holders in their own homes, making them feel comfortable. This assisted in enabling the respondents to share intimate information regarding traditional and western medical service systems. THPs were interviewed individually and were also involved in the focus group interviews with other respondent community knowledge holders. This means that the researcher visited the THPs individually so as to observe while the patients were being examined, and observed categories of customers who bought traditional medicine.

These interviews were also used to find out from respondent community members if there are ways and means of making sure of the sustainability of traditional medicinal plants for future accessibility for the future generations. An interview is a conversation between two people (the researcher and the respondent) where questions are asked by the researcher to obtain information from the respondent. The qualitative research interview seeks to describe the meanings of the central themes in the life of the community under study. The main task in interviewing is to understand the meaning of what the respondent is saying (Kvale, 1996). Different from the use of questionnaires, the method of the qualitative interview associates itself more with a constructivist hypothesis than a positivist one. It encourages more interaction between the researcher and the study community to obtain qualitative information. This was important for this study as it gave the researcher an opportunity to be actively involved rather than being just a passive listener in the researcher's own study. The researcher ensured that the knowledge holders had the opportunity to exquisitely express themselves in detail their own experiences regarding the research problem. The researcher only used an interview guide to direct the interview discussions, also took into consideration the additional information and suggestions for the respondents (Kvale, 1996).

The interview guide focused on exploring how community members (male and female) perceived the uses of traditional and conventional medicine. There were follow-up questions asked where necessary for clarity. The interviews were tape-recorded with the consent from the respondents. Respondents were assured anonymity and confidentiality of the interview. The interviews took about 30 minutes each. The researcher found the respondents through embarking on house-to-house surveys to locate key informants' addresses. The interviews were carried out in the respondents' homes or their own preferred locations to ensure that they were comfortable enough to freely participate and offer full cooperation.

In this study, more females (7) than males (3 males) were interviewed as the community is predominantly composed of women due to male labour migration. Women also have a role being health care givers to their families or households and the community at large. They were the main users of both traditional and conventional medical services.

The study recognises the potential weaknesses in interviewing as a technique of discovery as even confidential interviews may not necessarily generate the truth but only what the person being interviewed is willing to share at that particular moment (Becker, 2000). As a result,

even during interviews for this study, this type of limitation was acknowledged and taken into consideration.

Participant Observation

Interviews were accompanied by the use of participant observation. Interviews on their own were not adequate for this study; therefore, they were enhanced by the use of participant observation to improve the validity of the results. Participant observation was the primary method with two to three days per week spent in fieldwork over a period of three months. Due to familiarity with the study community language (Setswana), the researcher was able to participate in the respondents' daily interactions. The researcher kept a field diary where she noted all interactions observed, took videos, and recorded all the naturally occurring communicative interactions with the participants in a variety of activities of their lives, especially during data collection. The recording of videos and audios was done voluntarily with the consent of the participants. To ensure the researcher's access to the community members, especially key informants, and to ensure that data collection occurred from multiple perspectives, the researcher had to recruit key community members in the study community. Moreover, the researcher had to stay with the THPs and the community members who treated illnesses themselves by going to the bush to harvest relevant medicinal plants to heal the families. The researcher also visited the herbalists' workshops and homes for more insights. This was to enable the researcher to understand the medicinal plants that were being used and sold to people in the community and other customers from outside the community.

The researcher got permission from the THPs, herbalists and community at large, to observe how different ailments were treated with these medicinal plants. Nonetheless, the researcher observed the utilisation and selling of TM by both THPs, herbalists, and those who harvest it and use it at home. This provided the researcher with first-hand information, which is very important in any research undertaken. Furthermore, participant observation assisted the researcher in generalising the findings of the study, especially since the researcher understood the language and culture of the study community. Furthermore, the researcher was also familiar with traditional medicines used in the Batswana culture among the Coligny community.

The utilisation and selling of TM by THPs, herbalists, and other community members who have significant knowledge on TM was interpreted in the study. In this way, participant observation assisted the researcher to collect observed data (Kawulich, 2005). This means that the researcher had an understanding of the concepts used by the respondents as this is a method

that focused on the specific problems experienced by communities. Therefore, research was used as a way to identify those experiences affecting the community. Participant observation therefore, enabled the researcher to understand the reality of Coligny community members. The researcher observed various tactics used by THPs in the mixing of their TMs to treat different ailments. This method of data collection alone could not study the community without getting actively involved in the lives of the community members themselves, or at a distance. This means the researcher had to establish a relationship with the study community members so as to understand their way of life (Bless, 2007).

Observation does not only mean ‘seeing’; it is most often used to include ‘hearing’, as well as using other senses to collect information, for example, on temperature or smell. In real life the acts of perceiving, interpreting, assessing, and reacting, for example, can often seem simultaneous (think, for instance, about those processes in our decisions to cross a busy road). For some, observation can mean all of these things together (Malderez, 2003).

Participant observation is used because it affords the researcher an opportunity to notice and understand how the respondent community members communicate with one another, and how long they spend time together involved in different activities. Furthermore, it also allows the researcher to be able to notice all the non-verbal communication amongst the respondents (Lindlof et al. 2002). Furthermore, participant observation can be used in many different disciplines to collect as a method of collecting data about people, or culture in a qualitative research.

Bell (2014) also states that participant observation can also be used to increase the validity of the research or study. In this case study, observations assisted the researcher to have a better understanding of the perceptions within the community by participating in their daily activities including medical services. Similarly, the main objective of conducting research using participant observation as a method was mainly to develop a holistic understanding of the perceptions of the local community members on the research problem. The researcher participated in different activities relevant to the research problem.

One of the limitations of using participant observation is that sometimes the researcher must rely on the use of key informants and not be interested in what happens out of the public eye (Kawulich, 2005). Sometimes it is difficult for the researcher to be accepted in the communities in which they wish to conduct their research. This may be because the communities may fear that their knowledge will be stolen or distorted. According to Bergold et al. (2012), the

researcher may not be allowed into the community to conduct his or her research based on the way they dress, their age, appearance, class, one's ethnic group, and gender. However, this was not the case in this study as the study community is female dominant, and the researcher understands cultural significance in the community.

Another limitation of using participant observation is that the researcher is forced to engage in foreign culture and have to study the lives of other people as a full time community member for the whole duration of the research. It is a limitation as the researchers have to change their ways of living as a way to try and fit into that community where the study is conducted. However, this was not the case in my research as I originate from the community; I am familiar with the culture, language and the way of life in the community.

The overall objective of combining these research methods was to explore people's knowledge and experiences in relation to the research problem to gain an understanding on how the community members perceived the use of traditional and conventional medical services both theoretically and in practice. Furthermore, using a combination of these research methods provided a better understanding of how members of Coligny perceived the research problem and its implications for policy.

Permission to record the interviews and conversations was sought so as to allow the interviewer to focus on the interviewees, their responses, not with note taking. Questions pertaining to the interviews were listed on the informed-consent sheet that each interviewee signed. In addition to respecting the privacy of the respondent, the researcher ensured anonymity of the respondents, by creating an environment of comfort and trust. Furthermore, the researcher also ensured that there was flow of views and insights from each respondent throughout the study by making the respondents comfortable. The participants were further given choices of withdrawing from the study whenever they felt they had lost interest to further participate in the study. To be able to protect the participants, their real names were kept confidential by assigning them pseudonyms when referring to their experiences.

Questionnaires

Another method that was used for collecting data in the study was a questionnaire. 'A questionnaire is a printed self-report form designed to bring out information that can be acquired through the written responses of the participants. This information acquired through a questionnaire is the same as the information acquired through an interview, but the questions tend to have less depth' (Ritchie et al. 2014)

Burns et al. 1993:368) state that one of the important reasons for using a questionnaire is the fact that it becomes easier for the researcher to identify the suitable person or people to complete the questionnaire, and that the participants are able to complete the questionnaires in their own time. Furthermore, face-to-face questionnaires can be longer than telephonic and postal questionnaires as it enables the researcher to collect more information (Oppenheim, 1992; British Market Research Association (BMRA) Research Toolkit, 2003). As a way of checking the acceptance of the questionnaire, a pre-test of the questionnaire was undertaken.

Questionnaires were personally administered and facilitated by the researcher to all the participants and their family members. All the questionnaires were written in English, but were verbally translated and administered in Setswana, which is the dominant language in the Coligny community. This proved the flexibility of the researcher. The researcher also completed questionnaires for those participants who could not read and write. The reason behind the use of open-ended questions is that the researcher was able to get unanticipated findings in addition to the expected ones (Neuman, 2014). Moreover, the open-ended questions ensured that the respondent community knowledge holders provided relevant answers and expressed themselves freely in their own words. This means the study has used open-ended questions whereby the researcher does not provide the respondents with a set of answers to choose from. Use of open-ended questions produced rich qualitative data.

Each respondent involved in the study was asked the same questions in exactly the same way, ensuring that all the respondents answered the same questions, hence making a questionnaire a reliable method of data collection. The questionnaires were anonymous, and were completed without the knowledge of other community members. This enabled the respondents to answer the questions openly and honestly as they did not get intimidated by the presence of other community members. The study used the questionnaire to collect the socio-economic demographic characteristics of the respondents. In this case, twenty females (20), and ten (10) males were selected to participate in the study. The data collection took a period of three months.

Focus group Discussions

The researcher also collected data through focus group interviews. Lindlof et al. (2002) look at focus group discussions as a form of qualitative research in which a group of people is asked about their perceptions, opinions, beliefs, and attitudes towards a product, service, concept, an

advertisement, idea, or packaging. Normally, questions are asked in an interactive group setting where participants are able to freely talk and share their knowledge with other group members.

Tracy et al. (2006) add and state that a group discussion produces data and insights that would be less accessible without the interaction found in a group setting-listening to others' verbalised experiences stimulates memories, ideas, and experiences in participants. This is also known as the group effect where group members engage in a kind of chaining or cascading effect; talk links to, or tumbles out of, the topics and expressions preceding it. Focus group discussions also provide an opportunity for disclosure among similar others in a setting where participants are validated.

Focus group discussions are not the most advantageous techniques for all research situations, due to the following factors: (i) the researcher plays an important role in handling the situation, but if the researcher is not experienced enough, it is very easy for the whole discussion to be dominated by a few people. (ii) It is difficult to have the participants share their real feelings towards some sensitive topics publicly. This can in turn influence the productivity of data. (iii) If a great deal of consistency in the results from a series of focus groups have been identified and it is very likely that the results from these sessions probably can represent a larger number of people. Focus group discussions cannot be projectable in the same way as quantitative study findings can be (Gray, 2003).

In this study, ten (10) focus group discussions were conducted to collect data. With the majority of the group members being females as are more females in the community than males, six (6) focus group discussions contained five to ten women each, while four (4) focus group discussions contained only men, also with members from five to ten (5-10). The researcher was the facilitator of each focus group discussion which took an hour in a day. All these were done with the consent of the respondents.

The focus group interviews were used as a way to ensure that all viewpoints of the respondents were adequately represented. The study ensured that community members, with more emphasis on women, were given the opportunity to participate in the focus group discussion because they were more knowledgeable in terms of traditional medicine.

3.4. Data Analysis

The data was analysed and transcribed manually. In-depth analysis of relevant secondary data sources such as published and unpublished books and journals was made. Data gathered from

interviews, questionnaires, participant observations and focus groups were analysed through quantitative content analysis with the aim of quantifying emerging characteristics and concepts. Lewis-Beck (1995) states that data analysis is a process of inspecting, cleaning, transforming, and modelling data with the goal of highlighting useful information, suggesting conclusions, and supporting decision making.

Content analysis is the process of analysing verbal or written communication in a systematic way to measure variables quantitatively interpreted and discussed thoroughly in the study (Polit et al. 1995). Data was obtained through note-taking, and the use of tape recorders. The notes were captured during and hand written during the conversations, and the data collected with the use of tape recorders were transcribed after data collection. Additional information from the respondents after data collection was also taken into consideration.

3.5. Ethical Considerations

Ethics are systems or laws which guide the practice of a profession. It states how information and respondents' relationship should be managed. Code of ethics and the laws are mutually exclusive. An action may be legal but unethical. However some acts are both illegal and unethical. Ethical considerations occur when you are asked to use these rules to better serve your clients, or respondents (Becker, 1996).

According to Creswell (2009) ethical considerations are concerns that have to be taken into account in a research to conform to what has been said. The researcher has to conduct him or herself to conform to ethical standards and professionalism. The conducting of research requires not only expertise and diligence, but also honesty and integrity (Bell, 2014). These were observed to protect the rights of research participants. To render the study ethical considerations, the rights of self-determination, anonymity, confidentiality and informed consent were observed. The researcher obeyed relevant traditional laws and institutional and governmental policies. The researcher also honoured rights, copyrights, and other forms of intellectual property.

The confidentiality and anonymity of the participants were obtained by the means of an informed consent and by not disclosing their names. Burns et al. (1993) define anonymity as when subject cannot be linked, even by the researcher, with his or her individual responses. Conversely, confidentiality means that the information provided will not be publicly reported in any way which identifies them (Polit et al. 1995). In this study confidentiality was ensured by not revealing the participant's identities when reporting or publishing the study.

Informed consent was obtained before the completion of questionnaires and interviews. Informed consent can be defined as the prospective subject's agreement to participate voluntarily in a study (Burns et al. 1995). The ethical principle of self-determination was maintained. Participants were informed about their rights to voluntarily participate, decline to participate and to withdraw from participating at any time without penalty. Most importantly, the participants were informed about the purpose of the study, the procedures that would be used to collect data and assurance that there were no costs involved or risks foreseen.

CHAPTER FOUR

THE SOCIO-ECONOMIC DEMOGRAPHIC CHARACTERISTICS OF RESPONDENT COMMUNITY MEMBERS: COMMUNITY PERSPECTIVES

The Coligny community members have always had a concern with regard to the fact that there is a limited research in terms of the medical needs of the people. Furthermore, the external researchers who have conducted research in communities such as Coligny tend to view the community's socio-economic and demographic characteristics such as religious affiliation, gender, marital status, educational qualifications from a modern point of view. The cultural significance and its variables that are so much important to the people and the use of TM that has been part of their lives for healing purposes become ignored.

Therefore, it is important for the study to firstly investigate the cultural perspectives of the respondent community members with regard to their socio-economic and demographic characteristics. These perspectives were presented in the method of narratives which expressed their cultural experiences on the significance of the various variables of socio-economic and demographic characteristics in relation to the research problem, that is, the use of traditional and western medical service systems in Coligny community. The community is ethnically, predominantly Tswana and hence the main African indigenous language of communication is Setswana. The findings are presented in the following sections.

As mentioned in the previous chapter, as a way to protect the participants, their real names were kept confidential by assigning them pseudonyms when referring to their experiences.

4.1. The Traditional Significance of Age Groups

The study wanted to establish the significance of the age group of respondents in Coligny community. Table 4.1 shows the percentage of age distribution of the respondent community members.

Table 4.1 Percentage of Age-group Distribution of the Respondent Community Knowledge Holders and Practitioners

Total number of respondents (Male=10; Female=20)

Age-Group	Male	Female
20-30	12	07
31-40	14	08

41-50	20	15
51-60	24	33
61 and above	30	37
Total	100	100

Table 4.1 shows that the majority of the respondents (Males=88% and Females=93%) were in the age group of 31 years and above. Focus group discussions and in-depth interviews indicated that this age group was an important aspect in the household matters, as well as the socio-economic lives of the community members. This means that every individual in the household had a role to play in terms of the healing of a family and community members at large.

The study wanted to obtain the knowledge of THPs since they have more knowledge than any other members of the community. The following narratives illustrate the traditional significance of age group in the Coligny community. As indicated earlier, the names used in these narratives are not real, but rather disguised to uphold the principle of confidentiality.

Rre Mocketile (a community member and a THP) explains in Setswana, a language dominant in the Coligny community:

Bongaka jwa Setswana kgotsa jwa setso le tiriso ya ditlhare tsa Setswana ga e kgetholole, segolobogolo jang mo dingwageng tsa baagi ba mo motseng o wa rona wa Coligny. Bana le bagolo ba tlhakane, ba dumela thata mo tirisong ya ditlhare tsa Setswana ebile ba jela dingaka tsa Setswana nala ka dinako tsotlhe go bona kalafi e e maleba. Gantsi o fitlhela baswa ba tlhoka kalafi mabapi le malwetse a sejeno, jaaka malwetsi a thobalano, ao a itsegeng ka puo ya sekgowa jaaka Sexually Transmitted Infections (STI's) kgotsa sexually Transmitted Diseases (STD's). Mme gantsi ba kopa kalafi kwa dingakeng tse di tlhomphegileng tsa setso mo motseng. Mongwe le mongwe yo o mo dingwageng tse di masomeamabedi le botlhano o bonwa jaaka motho yo o botlhokwa go ka rutiwa ka ga kalafi ya setso le botlhokwa jwa yona, mme ba rutiwa ke batsadi. Se ke tsela eo ntseng e dirisiwa go dira bonnete jwa gore kitso e ga e latlhege kgotsa ga e swe.

Setlhopha sa dingwaga se botlhokwa ka gore batsadi ba na le kitso e e tseneletseng ya meriane ya setso go feta baswa.

Go tlaleletsa mo go seo, baswa ba ba dingwaga tse di kwa godimo ga masome-amabedi le bone (25 years and above) ba letleletswe mo motseng go nna dingaka tsa setso. Fa ele pitso ya bone go tswa kwa badimomg ba bone. Se, se dirwa fela fa badimo ba se letlelela, kgotsa ba batla go nna jalo. Bagolo mo motseng o ke bone gantsi bao ba itsagaleng jaaka dingaka tsa setso kgotsa bomaitseanape mo merianeng ya setso kgotsa ditlhare tsa Setswana. Ka ntlha ya se, ba ruta baswa bao e le gone ba simololang go alafa go itse gole gontsi ka aga botshelo jwa ngaka ya setso, ditiro tsa bona, maitshwaro, le botlhokwa jwa go nna ngaka ya setso. Mo godimo ga moo, ba rutwa ka ga melemo e e farologaneng, tiro le tiriso ya meriane eo e e maleba. Go tlaleletsa foo, baswa ba rutwa thata ka malwetsi a popelo, tlhakatlhakano ya malwetsi a baimana. Mme gantsi malwetsi a, a itsiwe thata ke dingaka tsa setso.

Rre Mocketile indicated that Tswana traditional healing practices do not have any distinctions, especially in terms of age groups. Both the young and the elderly have a strong belief in the use of TM and consult THPs all the time to get relevant medical assistance. Mostly the youth find themselves in need of medical assistance, especially for Sexually Transmitted Diseases (STD's) or Sexually Transmitted Infections (STI's). They mostly seek help from the THPs. Age group plays a significant role in the use of TM as those above the age of 25 years are taught by the elderly about the importance of traditional healing. This has been used as a way of ensuring that indigenous knowledge does not die out. Age group is important because the elderly have more knowledge of TM and its healing practices than the youth.

Further to that, the youth who are older than twenty-four years are allowed to become THPs. This is only done when the ancestors allow one to do so. The majority of the elderly people in the community are the ones who are known to be THPs or who have significant knowledge on TM and its healing practices. The people chosen by the ancestors to become THPs have to be first taught by the respective THPs. They are taught about the life of a healer, various medicinal plants, their importance, relevance and how to consume TM. In addition to that, young people

are mostly affected by womb problems, and pregnancy complications. These illnesses are better known and cured by the THPs.

The study is of the view that the above narratives from the community members demonstrate the cultural importance of age group in the use of TM of the study community which tends to be neglected by western research approaches. The above narratives of the local community members of Coligny clearly shows the existence and cultural significance of age group in TM which is frequently not paid attention to by western research approaches. Fabricant and Earnsworth (2001) agree with this view and state that traditional healing is closely related to the culture as well as the belief system of the African people in remote areas such as Coligny.

4.2. The Traditional Significance of Gender in Coligny Community

The study wanted to establish the significance of the gender of research participants. This is important because the meaning of gender in a traditional setting such as Coligny differs from that of a Western perspective. This study indicated that the majority of the knowledge holders and those who are primary health care givers are women. Table 4.2 shows the percentages of gender distribution among community knowledge holders and practitioners.

Table 4.2 Percentage Gender Distribution of the Community Knowledge Holders and Practitioners

Total number of respondents (Male=10; Female=20)

Gender Distribution	Percentage
Male	22
Female	78
Total	100

Table 4.2 shows that the majority of female (78%) were community knowledge holders as opposed to the male (22%). Focus group discussions and in-depth interviews indicated that gender plays an important role in the household matters, and the livelihood of the community members at large.

Mme Ngwenya, who is a community member and a knowledge holder, explains in Setswana:

Basadi ba bantsi mo motseng wa Coligny ke bone ba thusang ka kalafi ya setso. Ba na le kitso e e tseneletseng

ka meriane e mentsi e e farologaneng ya setso le tiriso ya yone. Ba dirisa kitso e ya bone go alafa malwetsi a a farologaneng go akaretsa le go 'baya bana phogwana' jaaka e le bolwetse jo bo kotsi jo bo tlwaelegileng mo maseyeng a mannye. Go feta moo, bomme ba dirisa meriane jaaka 'ditantanyane' go thusa bana gore ba gole ba itekanetse, ka mebele e e maatla, le meno a a itekanetseng. Gape, basadi ka bo bone ba tswa mo matlong a bone, ba jela dingaka tsa setso nala fa ba tlhoka go sireletsa metse kgotsa matlo a bona. Ba na le go dirisa 'letlhoka la tsela' fa ba dira ditlhapiso mo lapeng go ntsha sefifi morago ga loso lwa mongwe wa losika mo lapeng, kgotsa go alafa mmele o o botlhoko le setlhabi. Bangwe ba le dirisa gonne ba dumela gore le tla ba thusa ga ba ile kwa patlatirong. Basadi ba ya nageng go batla meriane e e tlhokagalang go e dirisa go alafa malapa a bone. Gape ba le bantsi ba rata go ya kwa nageng go epa moriane o o itsagaleng ka leina 'pitsa' morago ga go tlhokafalelwa ke borre ba bone. 'Pitsa' e, le yone e dirisiwa go ntsha sefifi.

According to Mme Ngwenya, a lot of women in the community are the main health care givers. For instance, most elderly women are THPs and have a significant knowledge on many various medicinal plants. We use this knowledge to cure diseases such as *go baya ngwana phogwana*. It is an illness common and dangerous among the small babies. Furthermore, we use *ditantanyane* to help babies grow healthy and strong, with strong teeth. As women, we also go out of the households and consult traditional healers for them to use African TM to protect the households from witchcraft. We use a medicinal plant named *letlhokwa la tsela* for various reasons such as, cleansing ceremonies. We also use it to bring luck after the death of a family member, or to heal body pains for everyone in the family or even stabbing pains. Some also believe that chewing *ditantanyane* helps to be successful in job interviews. Moreover, women go to the bushes to get all the necessary herbal medicines to use for the health of their families. We also get ourselves a medicinal plant known as *pitsa* after the death of spousal partners for cleansing purposes.

Mme Makgalemela, also a community member and a knowledge holder, also explains in Setswana explaining that:

Mo dinakong tse di fitileng, borre e ne e le bone bao ba neng ba tshepilwe thata mo kalafing le tiriso ya meriane ya setso. Ba ne ba bonwa jaaka bone fela ba nang le bokgoni le kitso e e tseneletseng ya ditlhare kgotsa meriane ya setso tse di maleba go alafa malwetsi mo motseng. Ka fa letsogong le lengwe, o kaya fa banna ba le mmalwa fela ba itseng ka ga meriane le kalafi ya setso, le tiriso ya meriane eo. O kaya fa lebaka legolo e le gore banna mo motseng ga ba jele dingaka tsa setso nala kgapetsakgapetsa gonne ba ya fela fa ba tlhoka kalafi segolobogolo jang fa ba na le bolwetsi jo bo itsegeng ka sekgowa jaaka 'drop' eo baagi ba motse ba dumelang gore e bakiwa ke fa monna a ka tsena mo thobalanong le moswagadi. Go feta moo, o kaya fa go na le banna ba se kae fela bao e leng dingaka tsa setso ebile ba itse go le gonnye fela ka ga meriane ya setso.

Mme Makgalemela also explains that, a long time ago, only male traditional healers were trusted with regards to healing powers. They were seen as the only ones capable and knowledgeable of medicinal plants relevant for healing purposes. On the contrary, only a few male are involved in traditional medicine, both in provision and in the utilisation of traditional medicine. Mostly, males in our community scarcely consult THPs. They mostly consult only due to an illness known in the community as 'drop', which the community believe to occur after sexual intercourse with a widow. Only a few males in our community are THPs and have a little knowledge of TM and its practices as compared to us women.

A community member, Rre Mokhondo, states that:

Batho ba bomme gantsi ke bone ba bonang fa ngaka ya setso e tlhokagala mo lapeng, segolobogolo ka ntlha ya gore borre ba dula ba le kwa tirong. Go nna le puisano magareng ga mme le rre pele ba ka iponagatsa kwa ngakeng ya setso. Go tlaleletsa moo, ga se gantsi borre

ba iponagatsa kwa dingakeng tsa setso kwa ntle ga kitso ya mme kwa lapeng. Se, se diriwa ke lebaka la gore, gantsi bomme ke bone ba dulang ba itse gore maemo a ba letlelela go bona ngaka ya setso kgotsa go ya kwa nageng go ikepele meriane eo lelapa le e tlhokang. Se se diriwa ka ntlha ya fa mongwe mo lapeng a lwala kgotsa go tlhokagala tshireletso e e matlafetseng kgatlhanong le boloi. O fitlhela gape go tlhokagala gore fa mongwe wa lelapa a lwala a nne le ditoro tse re sa kgoneng go di tlhalosa kgotsa tse di bokete nyana mo go rona, segolobogolo jang ga ditoro tseo di akaretsa maloko a malapa ao a re tlogetseng kgotsa bao ba tlhokafetseng. Mme ka jalo, mosadi, gonne a na le kitso e ntsi thata, o nna le botlhale jwa go direla badimo modiro, oo re o itseng rona Batswana jaaka ‘mokete’ kgotsa go apewa bojalwa, boo re bo bitsang ‘bojalwa jwa badimo’ go fedisa bolwetsi kgotsa kgotlhang mo lapeng.

A community member, Ntate Makhondo, states that normally more women in different households in the community are the first people to notice when something is wrong or when a THP or a traditional ceremony is needed. This is because more males spend more time at work. Besides that, more men don’t consult traditional healers without the consent or knowledge of their partners. This is because of the knowledge women have. Even when a sick family member has a strange confusing dreams that involve family members who have passed on, women also know whether to consult a THP or handle the situation themselves. In this instance, having the details of the dreams on her mind and heart, women go to the bush and get a relevant medicinal plant which they use to cleanse the whole family or the sick person (cleansing ceremony known in Setswana as *mokete/modiro wa badimo*). Further to that, they also make traditional home-made beer, which is known in Setswana as *bojalwa jwa badimo* as a way to please the ancestors.

Focus group discussions, in-depth interviews and observations indicated that more females remained the harvesters of TMs in the study area as opposed to the males. They showed significant knowledge in prescribing dosages of different medicinal concoctions for both the young and the elderly. Furthermore, they showed an important knowledge in different

techniques of preparing medical concoctions. For instance, they knew the amount of time to cook different medicinal concoctions before consumption.

The study also noticed through observation that the role of women as THPs and as the main health care providers served many purposes. In this case, they gathered the TM while ensuring that they do not harm the environment. This was done by gathering these medicinal plants at correct times of the day as a strategy to avoid extinction or causing these medicinal plants to die out. This is because of the specialised IK they have of all the medicinal plants found in Coligny community. They also played a major role in the drying of these medicinal plants, processing and packaging. Females in different rural communities are more knowledgeable on TM and healing practices compared to the males (Pidatala, 2003).

For example, a community knowledge holder, Mme Babie went to the bush to get *kgaba* for her daughter when she was four months pregnant. This medicinal plant is used among and by pregnant women to avoid pregnancy complications such the womb discomfort, early labour pains causing premature labour and loss of the baby due to miscarriage. It also avoids maternal deaths of pregnant women. Normally, this medication is consumed twice a day, in the morning and in the evening just before bed time. Mme Babie pointed out that she could not afford western medicinal services because of no income in the family. Again she pointed out that in this case where *kgaba* is needed, she cannot afford to go to the free government clinic nearby. This is because the nurses there normally advice the pregnant young women to go back to their mothers and ask to be given this *kgaba*. These nurses normally say it is because western medicinal services do not have any knowledge or skills to assist further.

The study is of the opinion that, the acceptance of women in the Coligny community as THPs, health care givers and knowledge holders has impacted positively on both the young and old generations without regard to sexual orientation, that is either male or female. This shared knowledge in the community is important for sustainability, appreciative, clarification, and distribution of IKS for future generations. The United Nations (2004) indicates that due to gender inequality in many African communities, many indigenous women experience discrimination in terms of access to health care services. Western health facilities are far from their reach and cannot access them due to lack of service in their respective communities. Also, the cost for those modern service, and the negative attitude and unacceptable behaviours they get from some of the western health care givers are unacceptable. Furthermore, since men are

the ones who inherit the land, women are unable to access that land to gather traditional herbal medicines important for healing purposes.

4.3. Marital Status and the Use of Traditional and Western Medicine in Coligny Community

Mme Legotlo, a community knowledge holder, gives a perspective on marital status:

Ka Setswana seemo sa nyala, ke sone seo se kayang kgotsa se bontshang le go re sedimosetsa maemo a motho gore a o nyetse kgotsa o nyetswe fa e le mosadi, kgotsa ke motlhololagadi, le gore a o kile a nyalwa kgotsa nnyaa. Mo godimo ga seo, seemo sa nyala se kgona le go kaya fa motho le molekane wa gagwe ba kgaogane, kgotsa ba sa tlhole ba le mo lenyalong. Seemo sa nyala se botlhokwa mo motseng ono gonne go dilo dingwe tse di botlhokwa tseo batho ba nnang karolo ya tsone mo motseng, mme maemo a nyala a tsewa tsiya. Sekao, go na le dikopano tse di rileng, jaaka go nna mongwe wa leloko la batho ba ba romelwang go ya go dira mmuisano wa tsa magadi. Fa o ise o ikgolaganye mo lenyalong kgotsa o kgaogane le molekane wa gago, ga o tsenele kopano e.

Mme Legotlo states that one's marital status in the study area is seen as one way of explaining one's status regarding marriage, that is, one is single, divorced, married, widow or widower or separated from their partners. Marital status is important in this community because there are important social issues that are dealt with, and some take one's marital status into consideration. For instance, there are certain meetings such as being one of the people sent to do lobola negotiations, which takes marital status as very important. If you have never been married or have divorced or separated from your partner, you can never be allowed to be part of the negotiations.

The cultural aspects related to marital status as important community socio-economic and demographic variables are not considered in western ways of knowing and knowledge production when investigating the socio-economic and demographic characteristics of African

local communities. Table 4.3 shows the percentage distribution of marital status of the respondent community members.

Table 4.3 Percentage Marital Status Distribution of Respondent Community Knowledge Holders and Practitioners

Total number of respondents (Male=10; Female=20)

Marital Status	Male	Female
Married	50	50
Single	10	14
Divorced	8	5
Separated	14	6
Widowed	10	15
Cohabited	8	10
Total	100	100

Table 4.3 shows that the majority of the participants in the study (Male = 50% and Female = 50%) were married. Focus group discussions and in-depth interviews indicated that marriage was an important status and achievement in the household matters, as well as the socio-cultural lives of the community members.

Mme Molepo, community knowledge holder assets that:

Lenyalo mo motseng wa rona re bona e le phitlhelelo e ntle tota, eo e ikgethileng mo go mang le mang, go sa kgathalesege gore o na le dingwaga tse kae; o le moswa kgotsa mogudi. Ke sone seo o bonang dingaka tsa rona tsa setso di le dintsi le tsona di le mo lenyalong. Mme ka lenyalo le bonwa jaaka mpho go tswa kwa badimong jwa monyadi le monyadiwa, ba lelapa la ga monyadi ba ntsha magadi go kopanya malapa a mabedi le badimo ba bona, mme go

tlhabiwe ka letsatsi la lenyalo go leboga badimo. Lenyalo le bonwa jaaka kopano ya malapa a le mabedi le badimo jwa bone, mme se ke phitlhelelo e e kgolo thata ke badimo jwa malapa a ba bonwa e le bona bao bat la matlafatsang lenyalo. Ka jalo, lenyalo le gokagane thata le badimo, le go ba itumedisa. Mo godimo ga moo, lenyalo le bonwa e le tsela ya go ka oketsa leina la lelapa, gore tshika ya lelapa e kgone go tswelela. Mme se se dirigala ka ntlha ya fa batho ba ba nyalaneng ba tshwanetse go tshola bana bao bat la tswelletsang tshika yotlhe pele, segolobogolo fa ba tshola bana ba basimane. Se ke ka gore bana ba basimane ba nyala, mme ga ba fetole maina a malapa a bone.

Mme Molepo states that the unity of two families through marriage was perceived as one of the many spiritual ways in which the ancestors bless both the marriage and the couples' families. Marriage was perceived as an invaluable achievement for both the young and the old. This explains the high marriage rate among the community knowledge holders and THPs. It is one of the social practices in the study area that was viewed as a great accomplishment for both males and females, and community at large. This is because marriage is seen as a way of expanding families, since the African culture is pro-large families.

Nonetheless, marriage is most importantly seen as a blessing from both God and the ancestors whom are trusted to ensure the prosperity in the lives of the married people. Mme Molepo reveals that, as the community, we consider marriage as very invaluable aspect for both the youth and the elderly. Hence majority of the THPs and knowledge holders of TM were married. This is because marriage is viewed as a gift from the ancestors of the two families; lobola is paid by the groom and his family to unite the two families and their ancestors. There is also the slaughtering of an animal, (a goat, sheep or cow) which is for the purpose of thanking the ancestors and asking for blessings as they are known to ensure the unity and prosperity in the marriage.

Mme Nofikile, a recognised community expert and member of herbal medicine in Coligny community, explains in her own comfortable language, Setswana:

Malapa a le mantshi mo motseng wa rona, batho ba malapa ao ba nyalane, kgotsa ba sa nyalana, a ikantse tiriso ya meriane ya setso ka dinako tsotlhe. Ka gorialo, mongwe le mongwe, go sa kgathalesege maemo a gagwe a lenyalo, o letlelesegile go ka dirisa meriane ya setso, kgotsa go nna ngaka ya setso. Motho mongwe le mongwe mo motseng, go sa kgathalesege gore o mo lenyalong kgotsa jang, o letlelesegile go nna ngaka ya setso, ka tetlelelo le mpho ya badimo ba gagwe. Le fa gole jalo, baagi ba motse bao ba nyalaneng, ba na le seriti thata, kgotsa ba tlhomphiwa thata go feta bao ba sa nyalanang. Ka go rialo, se banyalani ba se buang, kgotsa ba se dirang se reediwa ka tlhoafalo, kgotsa se tseelwa matsapa go na le se se tla be se buiwa kgotsa se diriwa ke motho yo o seng mo lenyalong. Ga o nyetse o le rre kgotsa o nyetswe o le mme mo motseng o tsewa jaaka motho yoo botlhokwa, yo o nang le dikakanyo tse di maleba, tse di ka tswelang motse wa lelapa la gago le motse ka kakaretso mosola. Go feta moo, fa o le mo lenyalong, o letlelelwa le go amogelwa go ka tsenela kopano e nngwe le e nngwe eo bagolo ba e tshwarang mo motseng, segolo bogolo jang fa e le dikopano tseo di leng mabapi le tlhabololo ya motse kgotsa sengwe le sengwe se se amang motse ka kakaretso. Ga o monna tota kgotsa mosadi tota fa o ise o tsene mo lenyalong. O santse o tsewa jaaka ngwana, mme o reetsa ditaello tsa batsadi kwa lapeng. Le fa o ka nna le bana kwa ntle ga lenyalo, o tsewa jaaka ngwana yo o santseng a tlhoka go laiwa, gonne ga wa nyalwa.

Mme Nofikile states that, most households in the community married or not, heavily rely on TM and its healing practices under any circumstance. This means that, married or not, one is allowed to go to the bush, gather medicinal plants, and consult a THP for medical assistance. Whether married or not, one is allowed to become a THP, and heal the sick, with the allowance and gift from the ancestors. Marriage in the community is more valued than any other aspects of life, in such a way that, married people are the ones who are more respected, they are

opinionated, are more listened to. What the married said or did was more important than the unmarried. This is because their opinions and ideas are considered more relevant, and more worthy and valuable to the development of their households and the community at large. Furthermore, the married are allowed and welcomed to attend tribal meetings or development related meetings more than the unmarried, even if the married is younger than the unmarried by age. One is not considered a real man or real woman if they are not married. Even if one has children but is still not married, they are considered to be children, and obey their parents, unless they get married, regardless of their age.

This shows that marital status in the study community is significant when related to TM. A married person was seen different from the rest and from when they were not married because being married comes with social status and respect. Discussions and decisions involving TM were attended to by those of the better social status only, that is, the married people. This is because they are seen as having necessary experience and initiation to partake in such issues. People in the study community have a belief that marriage is very closely connected to their ancestors, and culture, and this is a socio-economic demographic variable that does not exist in the western ways of living.

4.4. Level of Education and the Use of Traditional and Western Medicine in Coligny Community

The study wanted to establish the traditional significance of education on the use of traditional and western medicine. It firstly focused on obtaining the meaning of education from the study community members.

Mme Seganka, Coligny community member, explains the meaning of education:

Thuto kgotsa go rutega mo motseng wa rona e fetogile go nna selo se se bothokwa thata mo matshelong a rona. Thuto go ya ka maitemogelo a ka jaaka moagi wa motse ono nkare ke selo seo se se leele sa botshelo moo e leng gore batsadi ba fetisetsa thuto go bana le ditlogolwana tsa bona ka ga bokgoni, dilo tse bothokwa that mo botshelong, le kitso gore ba kgone go iphidisa. Thuto e ga e tshwane le eo bana ba e bonang kwa dikolong, jaaka basweu ba tle ba dire, mme ke

kgato e e tserweng ke motho yo o mogolwane, yo o nang le kitso e e tseneletseng go e fetisetsa go mo go ba bannye, go ba baakanyetsa bophelo mo motseng le gongwe le gongwe ko ba ka yang teng.

Mme Seganka explains that having knowledge or skills is seen as one of the most important things in the study our community as it is seen to open many doors. It is something that cannot be taken away from you. This knowledge and skills can only be shared with others, whereby the older generation passes it to the younger ones to help them survive. This knowledge is not similar to the one obtained in educational institutions as it is the case in the western environment. It is an initiative made by the knowledgeable elderly, to pass this Indigenous Knowledge to the youth, as a way to prepare them for social life.

The study wanted to establish the cultural significance of education of the respondents' knowledge holders of Coligny community members. This is because the meaning and understanding of education in indigenous rural settings is different to the one in a western setting. The following table, (table 4.4), focuses on the percentage distribution of educational level of the respondents' community members.

Table 4.4 Percentage Distribution of Educational level of the Respondent Community Knowledge Holders and Practitioners

Total number of respondents (Male=10; Female=20)

Educational status	Male	Female
Informal education	16	20
Primary	10	15
Secondary	21	15
High school	40	30
Tertiary	13	20
Total	100	100

Table 4.4 shows that the majority of the respondents, both male (54%) and female (50%) had high school education and above. Focus group discussions and in-depth interviews indicated

that education is an important aspect in the household and socio-cultural livelihood of the community members.

As one of the Coligny community members, Mr Mnyakama, a primary school teacher and a councillor, suggests in Setswana language that:

Kwa ntle ga thuto, bana ba rona ga ba kitla ba ya gope, ebile ga ba kitla ba nna sepe mo setshabeng. Thuto ke nngwe ya dilo tseo di agang bokamoso, mme ebile e bulela bana dikgoro tsa ditshono tse di atlegileng. Baswa ba tlhoka go rotloediwa go tsaya dithuto tsa bona tsiya, go tsaya matsapa le go dira ka thata go tsenya lesedi mo bokamosong jwa bone. Mo motseng o wa Coligny, batho ba le bantsi, go simologa ka baswa go ya go tsena kwa bagolong, ga ba rutega. Dithuto tsa baagi ba Tlhabologang di kwa tlase thata moo e leng gore batho ba feleletsa ba sa bone tiro ka ntlha ya dithuto tse di kwa tlase thata, kgotsa go sa nne le dithuto gotlhelele. Go ntse jalo ka ntlha ya go tlhoka bokgoni jwa go ka batla tiro e e maleba jaaka batho ba bangwe ba ba rutegileng. Le fa go le jalo, sengwe se ke itseng se sa tlhaole ka ntlha ya dithuto ke bongaka jwa setso. Mongwe le mongwe, go sa kgathalesege gore o rutegile kgotsa jang, o kgona go nna ngaka ya setso, fela fa badimo ba mo letleletse, ebile ba tlhophile ene. Fela, o tshwanetse gore o be o le mo dingwageng tse di maleba (masome a mabedi le botlhano go ya kwa godimo) go ka nna ngaka ya setso. Mo godimo ga moo, dingaka tsa setso di le dintsi, segolo bogolo mo go bao ba godileng thata, bao e ntseng ele dingaka tsa setso dingwaga di le dintsi mo motseng wa rona ga di a rutega. Mme se, ga se a ka sa ba thibela go ka direla motse wa bone ka matsetseleko. Mo motseng wa Coligny, batho bao ba rutegileng ke bone gantsi ba kopang thuso gotswa kwa dingakeng tsa setso. Ba kopa thuso gonne ba batla tshireletso kgatlhanong le boloi,

mme bangwe ba batla badimo ba bona ba ba bulela ditsela go bona tiro eo ba ntseng ba e labalabela mo dipelong. Gape, ba sireletsa sengwe le sengwe seo ba nang le sone, jaaka matlo, dikoloi, le go dira bonnete jwa gore ba tswelela mo botshelong. Bao ba sa ruteng ba kopana le dingaka tsa setso gonne ba tlhoka lesedi mo botshelong, go bona tiro, go itshireletsa kgatlhanong le dira tsa bone kgotsa bone boloi, go isa malwetsi a rileng, le go sireletsa malapa a bone le go dira mekete.

Mr Mnyakama points out that, without education, the younger generation will not succeed and that, they will never amount to anything in their own nation. Education is one of the things that build the future, and open many bright and good opportunities. The youth need to be encouraged to take their education into consideration, make efforts, and work hard to have a future with many opportunities. In the Coligny community, from the elderly to the younger generation, the level of education is very low as many people are not educated. The level of education among the community members of Coligny is very low or do not have any educational background. This prohibits or stand in their way to get proper employment. This is due to lack of skills, which could enable the community members to compete for proper employment with the educated in their community or anywhere else in the broader society. Even so, one thing that I know does not discriminate in terms of the educational background is being a THP.

Regardless of whether one is educated or not, anyone can become and consult a THP which is viewed as a gift from one's ancestors. However, to be a THP, one needs to have attained the right age (25 years and older). Furthermore, many of the THPs in this community are not educated, and have never went to any educational institution before, especially those of the elderly, and who have been involved in traditional healing for many years. However, this did not come as an obstacle to their desire to serve their community. Mostly, it is the educated individuals who seek the THPs' medical assistance compared to those who are uneducated.

The people in the community seek help to be protected from their enemies and witchcraft, and ask the ancestors to open their doors for the employment they desire. They also utilize TMs to protect their assets, such as houses and cars, and to bring success in life. As for the uneducated, they consult the THPs to protect themselves from witchcraft, for healing when they feel sick.

Also, they consult THPs to protect their families, as well as for guidance in conducting ancestral ceremonies.

The study agrees with what Mnyakama had to say, when he indicated that no formal education is needed for one to become knowledgeable with IK and becoming a THP.

4.5. Distribution of Household Sizes and the Use of Traditional and Western Medicine in Coligny Community

The study wanted to establish the role of the household sizes of the respondents. This is because household sizes in traditional rural communities tend to differ from those of the western, due to different values and belief systems. The following table illustrates the percentage distribution of respondents' household sizes.

Table 4.5 Percentage Household Size Distribution of Respondent Knowledge Holders and Practitioners

Total number of respondents (Male=10; Female=20)

Household size	Male	Female
One	25	15
Two-four	30	20
Five-seven	15	25
Seven and above	30	40
Total	100	100

Table 4.5 shows that the majority of the respondent households, both male headed (75%) and female headed (85%) had two members and above. Focus group discussions indicated that household size plays an important role in the household matters, as well as the socio-cultural livelihood of the community members. Every member of the household had a responsibility to fulfil in order to ensure the good health of each member. The bigger the household size the greater was the demand for medical attention whenever there is an illness to avoid worsening. The importance of household sizes in Coligny community was articulated by one of the community member, Mme Babie:

Ke gola ke le ngwana wa bone mo lelapeng la bana ba le
robedi, la basetsana ba le thataro, le basimane ba le

babedi. Ke gola jaana mme e le segole mo leotong la molema, mme a sa bone, leitho la gagwe la ka fa mojang le sa bone gotlhelele. Rre wa rona o ne a na le kitso e ntsi ka ga meriane ya setso, mme ebile e le ene yoo o thusang balwetsi mo motseng le mo lapeng la ko gaetsho. Ka jalo, o ne a ya kwa nageng, segolo bogolo mo mesong, le fa letsatsi le ya phirimong go batlana le meriane e e bothokwa, eo a itseng gore baagi mo motseng wa rona ba e tlhoka thata ebile e ba thusa. Ka ntlha ya go tlhoka madi, re ne ra reteletwa rotlhe jaaka bana go isiwa sekolong. Le fa gole jalo, rre o ne a rata re tsamaya le ene, fa mme a ile tirong, go ya go batla meriane go alafa malwetsi mo motseng. O ne a re ruta mosola wa meriane e e farologaneng, tiriso ya yone, le ka mokgwa oo e apewang ka teng go alafa malwetsi a a farologaneng. Ke ka moo re nnileng le kitso ya go alafa mme wa rona, le bokgaisadi ba rona nako nngwe le nngwe e ba lwalang ka yone, ga mmogo le bana ba rona.

Mme Babie states that she grew up as the fourth child of eight (8) children at home, that is, six (6) girls and two (2) boys. Their mother's left foot was handicapped, with a blurry left eye, and no clear vision. The father had a significant knowledge of all the medicinal plants one can think of, which he used to cure the family's ailments and the village at large. He would go to the bush, especially very early in the morning and at sunset, to look for important and relevant medicinal plants which the community heavily relied upon. She further states that, due to lack of sufficient funds to go to school, all the eight children were not able to go to school. Even so, they would go with the father to the bush, while the mother was at work, where we would gather different medicinal plants for healing purposes. She had this to say:

We were taught about these different medicinal plants, their importance, how to use and properly prepare them. As a result, we were able to help our mother whenever she got ill, as well as other siblings in the family, and our children.

The study is of the view that, people in the study area are still practicing their culture that, believes in large, extended families which goes in line with the essence of *Ubuntu*. It comes with a belief that family members, together with relatives stick together, and take care of one

another. It also suggests that the community cares for one another, and that people are to see one another as brothers and sisters even if not biologically related (communism). This study also had an interest in the employment status of the respondent community members of Coligny community.

4.6. Employment Status and the Use of Traditional and Western Medicine in Coligny Community

In this section the study wanted to establish the community's perspectives on the employment status in relation to the use of traditional medicine. The study found it appropriate to firstly find out the meaning of employment from the community members themselves.

Mme Mogale, community elder, provides her own perspective on employment status:

Go rekisa meriane e e maleba ya setso go re thusa go direla bana ba rona ka re kgona go ba fepa ka madinyana ao re a boneng go tswa mo kgwebong e. Mo motseng wa rona tiro e gantsi e e netefatsang gore re bona kalafi ke tiriso ya meriane ya setso kgotsa ya Setswana, eo batho ba e bitsang kalafi ya setso. Le fa ele gore bana le borre baswa ban a le karolo eo ba e tshamekang mo karolong e, gantsi o fitlhela e le batho ba bomme ba leng matlhagatlhaga thata mo go yone, ka ele bone bomaitseanape ba kalafi ya Setswana mo malapeng le mo motseng ka kakaretso. Ka jalo bana ba ithuta ka ga mefuta e e farologaneng ya meriane ya Setswana go netefatsa gore kitso ya batsadi ba bone e dula e le teng, ga e nyelele, ebile ga e lebalwe.

According to Mme Mogale, the most important activity that ensures healing in the community is the use of traditional medicine. Selling relevant traditional medicines as herbalists helps us as the bread winners to our families and put food on the table. Even though males and the youth play important roles in ensuring good health, women play a major role in healing both their families and the community at large. The younger ones tend to learn about different types of traditional medicine, and this enables the knowledge to be preserved rather than lost.

Table 4.6 illustrates the percentage distribution of employment status of the community knowledge holders.

Table 4.6 Percentage Distribution of Employment status of the Respondent Knowledge Holders and Practitioners

Total number of respondents (Male=10; Female=20)

Employment status	Male	Female
Employed	20	10
Unemployed	46	53
Pensioner	14	27
Farmer	20	10
Total	100	100

Table 4.6 shows that 46% of the male respondents and 53 % of the female respondents were unemployed. Focus group discussions and in-depth interviews indicated that the employment status plays an important role in the household matters as well as the socio-cultural and economic livelihood of the community members. The importance of the employment status of the Coligny community members was expressed by one of the community members, Mme Thantshi, stating:

Jaaka dingaka tsa setso le bone e le batho, ba tlhoka go ja le go duela bodulo, ba tlhoka madi nyana a rileng go iphidisa, go tswa mo bokgoning jwa bone jwa go alafa balwetsi. Bonnye joo ba bo bonang go tswa mo kalafing bo dirisiwa ke bone dingaka tsa setso go tlhokomela ba malapa a bone. Se ke tiro eo kalafi ya setso e e tlohang mo motseng wa rona. Mo godimo ga moo, ngaka ya setso e dirisa bonnye jwa madi go bona mmuisano go tswa mo badimong jwa molwetsi, go bona gore bolwetsi joo bo tlholwa ke eng. Gape, meriane e mengwe o fitlhela a se teng mo motseng wa rona, ka jalo, ngaka ya setso e tshwanelwa ke go ya ko metseng e mengwe go batlana le meriane eo, ka dinako tse dingwe, meriane eo ga

fitlhelesege ko nageng, mme ngaka ya setso e tshwanelwa ke go reka meriane eo kwa dingakeng tse dingwe tsa setso, gantsi go tswa kwa dinageng tse di kgakala, mme madi a tlhokagala foo. Kalafi ya setso e dira gore dingaka tsa setso di nne di le teng kwa malapeng a bona fa baagi ba motse ba ba tlhoka, gonne ga ba tlhoke lobaka la go ya go batla tiro kwa metsesetoropong go iphidisa. Ka jalo, go alafa go ga setso, ke tiro ka bo yone.

Mme Thantshi asserts that, because THPs are also human, and therefore need to survive, they need the little money they charge their patients for survival. They need the little they receive to put food on the table for their families. This is the type of employment traditional healing provides in the community. Furthermore, the little they receive is believed to make communication with ancestors possible, which is important in revealing the causes of ailments among patients. At times, some TMs are not found in the bush in the community, and for that reason, the THPs need to travel to other locations or villages just so they can have access to those herbal medicines. Mostly, they have to buy these medicinal plants from other THPs in other areas, even from afar. For this reason, money is needed for them to do all this. Traditional healing makes it possible for the THPs to be available to the community at all times. Therefore traditional healers do not have to go to the cities to look for employment opportunities, thus, traditional healing is a work opportunity itself.

Another community member, Rre Cornelius, adds on what the previous respondent, Mme Thantshi, has said above. He states:

Ga gona ka mokgwa oo badimo ba gago ba ka go thusang kwa ntle ga go ntsha bonnye jwa madinyana ao o nang le one. Se ke go bontsha gore molwetsi o tlhompha badimo ba gagwe, o tlhoka dikarabo kgotsa maele go tswa mo go bone ka ga bothata joo a iphitlhelang a le mo go bone. Gape, ke go bontsha gore molwetsi o bontsha fa go nna teng ga badimo ba gagwe mo mererong ya botshelo jwa gagwe gole botlhokwa thata. Re duela madi a mannye fela mo dingakeng tsa setso go bona thuso e e maleba. Le

fa o sena madi, ngaka ya setso e kgona go go thusa, mme molato o tla boa o duelwa morago fa molwetsi a na le gone. Mo godimo ga moo, batho botlhe go sa kgathalesege maemo a bone a go thapiwa (ba na le tiro kgotsa ba sena yone) ba dula ba kopa thuso mo dingakeng tsa rona tsa setso. Se, ke ka ntlha ya gore tlhwatlhwa ya meriane ya setso e kwa tlase thata. Go feta moo, rona bao re senang tiro re kopa thuso mo badimong go re neela tiro ka go ya ko go maitseanape (ngaka ya setso) mme re atlege fa badimo ba itumetse. Ba tlhaba setlhabelo, ka maele a ngaka ya setso e le tsela ya go kopa badimo go ba tshagofatsa ka tiro. Bao ba nang le tiro ba kopa thuso gore ba se ke ba latlhegelwa ke tiro kgotsa ba tlhatlhosiwe kwa tirong. Ba dira jaana ka go tlhabela badimo ba bone setlhabelo, ka thuso ya ngaka ya setso, e le tsela ya go leboga badimo ba bone. Le fa gole jalo, ka ntlha ya botlhoka tiro jo bo feteletseng, borre mo motseng wa rona ba ile ba tshwanelwa ke go ya metsetoropong go batla tiro go tlhokomela ba malapa a bone. Mme se se dira gore basadi ba le bantsi mo motseng ba nne le maikarabelo otlhe a go tlhokomela bana ba bone, le go netefatsa gore lelapa lotlhe le itekanetse. Ka gorialo, basadi ba, ba ne ba tshwanelwa ke go ithuta go le gontsi ka ga meriane ya setso go alafa ba malapa a bone, go akaretse motse wa Coligny ka kakaretso. Se se tlholwa ke gore meriane ya setso e tlhwatlhwa tlase, ebile ga ba kgone go fitlhelela meriane ya sekgowa gonne tlhwatlhwa ya yone e le kwa godimo thata.

Rre Cornelius states that, there is no way one can get any medical assistance or some sort of communication regarding the illnesses from the ancestors without paying with the little that one has. He states that this is a way of showing respect to the ancestors, acknowledging their existence and presence in one's life, and also as a way of seeking answers. He further states

that, they (community members) only pay a little to get the relevant medical assistance. At times, when you do not have enough to pay for the consultation, the THPs still assist, and then the rest of the outstanding amount is paid later on, when the patient is financially stable.

Rre Cornelius further asserts that, everyone in the community, regardless of their employment status, do consult THPs. One of the main reasons is the fact that TM is affordable, and hence, everyone has access to it. The unemployed consult the THPs mostly to bring luck to job searches, and the communication with the ancestors and pleading with them to assist them with this regard. A cow, sheep or goat, is slaughtered under the supervision of THPs as a sacrifice as blood is shed, for the ancestors to grant the wishes of the patients.

For those employed, THPs are consulted as they wish to safe-guard their employment or wishes to get promotion at work. There is also a sacrifice in this case whereby the people slaughter a cow, sheep or goat to please the ancestors, so that they can grant their wishes. Even so, because of the high rate of unemployment in the community, most of our male residents have moved to the cities in search of employment opportunities, leaving women to struggle on their own with the children including the medical well-being of the entire household. This has forced women to depend more on traditional or indigenous healing, as they cannot afford western medical services.

The study found out through the use of focus group discussions and in-depth interviews that the respondent members of the community are experiencing a high rate of unemployment, which is highly felt by females than males. A small number of people are permanently employed. This is worse in the case of women as fewer of them are employed. Hence, some of these women depend on small informal businesses where they sell vegetables, fruits and some other food items on the streets, taxi ranks and in towns to survive. Furthermore, this means that more of the community members, especially women, cannot afford modern medical services or consult western doctors in town. TM is more convenient for them as it is affordable, and the community members themselves can go to the bush and gather traditional medicinal plants on their own.

In-depth interviews and focus group discussions revealed that, not many people in the study area can afford western medicine and its facilities. High unemployment which is caused by lack of skills, and brings about poverty makes it almost impossible for people to be able to consult western medical health practitioners.

The study therefore is of the view that, more people rely heavily on TM than western medicine because it is less expensive, it is more accessible, and THPs are always available at any point in time to assist the ill. Muller and Steyn (2002) agree with the study, and state that THPs are more available as they reside in the same area, and not far from the community members, especially in rural areas where the western medical facilities are out of reach due to distance. The medical services of the THPs are also affordable to the local people, especially those in poor rural communities (Aitken, 2003).

4.7. Religious Affiliation and the Use of Traditional and Western Medicine in Coligny Community

The study wanted to establish the significance of religious affiliation of the community knowledge holders and practitioners. This is because religious beliefs have an influence in the choices the people make, especially their health issues. The study wanted to establish the perception of community knowledge holders regarding the significance of religion and the use of TM and healing practices.

Mme Seralo, a community knowledge holder, gives a meaning of religion:

Tumelo e kaya sengwe le sengwe se motho a itlhophelang go dumela mo go sone, sengwe le sengwe se se maatla go go feta, seo se go nayang maatla, le go go bontsha tsela le boammaruri gore o phele bophelo jo bo siameng. Ditumelo tsa batho ga di tshwane, sekao, bangwe ba dumela mo Modimong, fa bangwe ba dumela gore ga gona Modimo. Bangwe ba rapela Modimo oo ba itseng ka ena ebile ba dumela go ena ka ntlha ya Beibele, mme bangwe ba dumela mo medimong ya diseto. Go tlaleletsa foo, bangwe ba dumela fela mo badimong, fa bangwe bana le tumelo e matlafetseng mo Modimong le badimo.

Mme Seralo states that, religion is anything that one chooses to believe in, anything that is superior to their being, and gives them strength, and guides them to live a fulfilling and a righteous life. Religion differs from one person to the other. For examples, others believe in and worship God, others do not believe in the existence of God and others believe in worshipping idols.

Table 4.7 above illustrates the percentage distribution of religious affiliation of the community knowledge holders and practitioners

Table 4.7 Percentage Religious Affiliation Distribution of the Respondent Knowledge Holders and Practitioners

Total number of respondents (Male=10; Female=20)

Religious affiliation	Male	Female
African Religions	60	60
Christianity	30	30
Islam	10	10
Total	100	100

Religious beliefs have an influence in the choices that people make in life. It plays a major role in determining the character and economic behaviour of individuals and as members of the society. Table 4.7 indicates that the majority of the respondents both male (60%) and female (60%) were affiliated to African Religions. Focus group discussions and in-depth interviews revealed that the people in the study area regard their religious belief systems to be closely related to their ancestors and traditional medicine. This medical service system is in line with their culture and accommodates their spiritual well-being.

The role and importance of religion in Coligny community is articulated by one of the young females in the community, Kedibone, who states:

Bodumedi kgotsa ditumelo tsa rona di farologane that mo motseng wa rona. Ka jalo, re dira dilo le go phela ka mekgwa e e farologaneng. Bodumedi ba rona gantsi ke bone bo senolang fa re dirisa le go dumela mo tirisong ya meriane ya setso kgotsa tiriso ya meriane ya sekgowa, kgotsa di le pedi. Sekao, kereke eo ke e tsenang ka nako e (kereke ya bapholoswa eo e itsegeng ka sekgowa ka leina la Apostolic Faith Mission), e nngwe ya melaotheo ya yone ke gore tiriso ya meriane ya setso ga ya letlelelwa ebile fa o ka fitlhelwa o dirisa meriane eo o ka lelekwa mo setheong sa bone. Go feta moo, re le bakereki

kgotsa batho ba setheo se, ga re a letlelelwa go ka nna le kamano epe le dingaka tsa setso le meriane ya bone. Gape, le fa dingaka tse tsa setso e ka nna ba masika kgotsa ba malapa a rona, ga re a letlelelwa go ka ikgokaganya le bone, kalafi ya bone le ditiro tsa bone tsa kalafi. Se se tlholwa ke gore, kalafi ya meriane ya setso le dingaka tsa yone di bonwa jaaka kalafi e e ka gokaganngwang le ditiro tse di bosula. Go feta moo, re rutiwa le go bolelelwa teng kwa kerekeng fa dingaka tsa setso di sena nnete ka kalafi epe ya bone, mme ba ipatlela fela madi a baagi mo motseng. Kalafi le meriane ya setso e bonwa jaaka sengwe seo se leng kgatlhanong le Bokeresete le beibele ya Modimo le ditsela tsa gagwe.

Kedibone stated that;

Our religion as the Batswana tribe in the community differs a lot. In that sense, we do things differently, and live differently. Our religion is the reflection of what type of medical service system we use, that is, traditional or western. For example, the church I attend, named the Apostolic Faith Mission, prohibits us the church members to be in contact with traditional medicine, let alone have any relation whatsoever with the THPs. Otherwise, we would lose our membership to the church. Even if the THPs would happen to be our relatives or families, we are not allowed to be part of what they do, or have anything to do with them. This is because traditional healing is regarded as a practice that is ungodly. Further to that, we are taught in church that THPs do not have the truth about their healing practices, and only want money from the patients. It is a type of healing that is seen to be against Christianity, God, as the use of TM is perceived ungodly, and of the dark spirits.

Another community member, an elderly, Mme Lizah, agrees with what Mme Kedibone has stated above, and opines that:

Le bone batho bao e leng gore ba tsenetse ditheo tseo tsa Bapholoswa, ba dirisa meriane e ya setso ka dinako tsotlhe. Ba dira jalo mo sephiring, gonne ba sa batle go lelekwa kwa dikerekeng kgotsa ditheo tsa bone. Fela jaaka kereke e nngwe teng mo motseng mo eo e

itsagaleng ka leina la Zion Christian Church (ZCC), eo batho ba teng ba sa letlelelwang go ka dirisa meriane ya setso le go nna le kgolagano epe le dingaka tsa setso, ba e dirisa fela mo sephiring. Batho ba ditheo tse le tse dingwe, bana, bagolo le baswa, go akaretsa baimana, ba bona thuso kwa dingakeng tsa setso. Sekao, baimana ba na le go tlelwa ke ditlhakatlhakano, mme ba dirisa moriane oo o itsagaleng mo motseng wa rona jaaka 'kgaba' go bona kalafi. Se ke ka ntlha ya gore gantsi thuso kwa ditheong tsa sekgowa tsa kalafi ga ba bone thuso, mme baoki gantsi ga ba na kitso ya ditlhakatlhakano tse le gore di tsholwa ke eng. Ka jalo, o le mopholoswa kgotsa moAforika jaaka nna, o feleletsa o kopa thuso kwa dingakeng tsa setso. Ka jalo, Bokeresete ka dinako tse dintsi ga bo tsewe tsiya fa kalafi e tlhokagala ebile bophelo jwa motho bo le mo kotsing.

Lizah states that;

Even those who claim to be born again Christians depend on TM at all times. They do this in secret to avoid being dismissed from their church. Just like the Zion Christian Church (ZCC), members are not allowed to use medicine from the THPs, but they do so in hiding or secret. People from these churches and others still go to the THPs for medical attention, that is, the children, adults, youth and even those pregnant. The pregnant women normally have pregnancy complications, and therefore use one of the most effective TMs in the community known as 'kgaba' from the THPs for healing. This is because the western health practitioners mostly do not know what the problems are, the causes, and therefore are not able to assist. As a result, whether you are a born again Christian or a purely African woman like me, you end up seeking help from the THPs

The study therefore is of the view that, the African religion, as reflected on the people in the study area and traditional healing are inseparable, and forms an invaluable part of their healing process. Bham and Ross (2005) agree with this view and state that TM and healing practices seem to be inseparable with religious beliefs of the African people. For instance, in the Muslim communities, ailments, and disabilities are seen as caused by God's will (Bham and Ross,

2005). Then again, many Black African people's cultures associate ailments and disabilities with spiritual contamination, whereby one is considered impure. This is believed to be as a result of being involved in an activity perceived to be tainted (Ellis, 1996).

CHAPTER FIVE

KNOWLEDGE AND PERCEPTIONS OF COMMUNITY MEMBERS TOWARDS THE USE OF TRADITIONAL AND WESTERN MEDICAL SERVICE SYSTEMS

This chapter focuses on the knowledge of respondent community members towards the use of traditional and western medical service systems. The use of TM and healing practices is part of the people's culture. The study intended to establish community members' knowledge and perceptions towards the use of the two medical and health care systems. The chapter is divided in the following sections:

- (i) Knowledge of community members towards the use of traditional and western medical service systems
- (ii) Perceptions of community members towards the use of traditional and western medical service systems

The first sections entail the awareness and knowledge of the Coligny community members on the existence and knowledge of diseases in their community, followed by the knowledge of community members on the various medicinal plants and different plant parts used for specific illnesses. This section also includes the community members' knowledge of the impact of TM on the environment, and concludes with the knowledge on the strengths and limitations of western and traditional medical service systems.

The second section focused on the reasons influencing the consultations of THPs, the reasons influencing the consultations of western health practitioners, as well as the reasons for the integration of western and TM or for consulting traditional and western health practitioners simultaneously.

5.1. Community Members' Knowledge of Traditional and Western Medicine

Coligny community is afflicted by a number of various types of ailments which require people to have access to sufficient medical service systems. The study wanted to establish the knowledge and awareness of the community members with regard to the existing common diseases in the community. Table 5.1 illustrates the percentage gender distribution of community members' knowledge of common diseases in Coligny Community.

Table 5.1 Percentage Gender Distribution of Community Members' Knowledge of Common Diseases in Coligny Community *

Total Number of Respondents (Male=10; Female=20)

Type of Disease	Male	Female
Womb infections	6	11
Chest pains	5	4
On-going headaches	5	5
Mental Disability	6	5
HIV and AIDS	50	50
High and Low blood pressure	10	5
Tuberculosis	9	10
Diabetes	9	10

* Respondents were allowed to indicate more than one common disease in the study community

Table 5.1 shows in spite of respondents naming a variety of common disease found in the community, the majority, both male (50%) and female (50%) indicated HIV and AIDS as the most common disease found in the community. The study was interested in establishing the extent of the community members' awareness of these diseases in the community. The findings are shown in Table 5.2.

Table 5.2 Percentage Gender Distribution of Community Members Awareness and Knowledge on the Existence of Diseases in Coligny Community

Total Number of Respondents (Male = 10; Female = 20)

Response	Male	Female
Yes	60	80
No	37	14
Not Sure	3	6
Total	100	100

Table 5.2 shows that the majority of respondents (Male=60% and Female 80%) were aware of the existence of diseases in the study community. The study wanted to establish the extent of the respondent community members' knowledge of the common medicinal plants used for various diseases in the study community. This was to obtain deeper knowledge of the African

medicinal plants that are used on a daily basis as well as their functions. The results are shown in Table 5.3.

Table 5.3 Respondent Community Members' Percentage Distribution of Knowledge of the Different Types of Traditional Medicines

Male			Female		
Disease	Plant Name	Plant Part Used	Disease	Name of Plant	Plant Part Used
Sexually Transmitted infections	Tshupu ya poo	Root	Menstrual Complications	Mosu	Branches
	Mmamashwi	Root		Mokgalo	and leaves
				Moselesele	Root
				Mofalatsa maru	Branches and leaves
Failure in Reproductive organs	Mothagala	Root	Reproductive organs	Mothagala	Root
	Morobe	Root		Morobe	Root
Headaches	Monnamontsu	Root	Headaches	Morobe	Root
	Lengana	Branches and leaves		Makgolela	Root
Mental illnesses	Bolebatsa	Leaves and braches	Mental illnesses	Moologa	Branches and leaves
Chest complications	Lengana	Branches and roots	Chest complications	Lengana	Branches and roots
Open cuts	Monnamontsu	Root	Open cuts	Monnamontsu	Root
Stomach pains	Phekolola	Root	Stomach pains	Phekolola	Root
	Kgalamela	Bulb		Kgalamela	bulb
Stabbing pains	Monepenepe	Root	Stabbing pains	Letlhokwa la tsela	Branches
	Setswenyakawena	Root		Monepenepe	Root
				setswenyakawena	Root
High blood Pressure	Motsitsane	Root	High blood pressure	Motsitsane	Root
	Moswarulwa	Entire plant		Moswarulwa	Entire plant
				Monamane	plant

				Mogato	Root Root
Cough	Mmaba Modisakswana Monoko	Root Bark Root	Vomiting	Tshupu ya poo Mohubu makgorometsa	Root Root Root
Diarrhoea	Monokwana	Root	During Pregnancy	Motsididi Morolwa	Root Root
			Womb pains	Mothagala	Root

Table 5.3 shows the diversity of knowledge of traditional medicinal plants by respondents for different ailments. As indicated, some medicinal plants were commonly known by both male and female respondents. For instance, males and females had different knowledge of medicinal plants used for headaches, and mental illnesses. Information from focus group discussions revealed that this allowed the community knowledge holders and THPs to have more options of substituting the medicinal herbs when the others were not available at the time it was required. Nonetheless, it was also indicated that females had greater knowledge of herbal medicines as opposed to males. For instance, females knew more herbal medicinal plants used for high blood pressure as well as for stabbing pains. Females showed a significant knowledge of traditional medicines used for vomiting, womb pains, and menstrual complication. They also showed significant knowledge on medicines used to prevent pregnancy complications, something the males knew nothing of. Nonetheless, *Mothagala*, and *Morobe* are known and used for failure in the reproductive organs for both males and females, using the same plant part, that is, the root. Furthermore, same plant, i.e. *Monnamontsu* was known and used by both males and females for open cuts.

Participant observation also assisted the researcher to discover that the illnesses and diseases that the community experienced were considered better healed by the THPs as opposed to the western medical practitioners. Observations revealed that amongst the people who purchased traditional medicines from herbalists, females knew the types of medicinal plants they needed for different ailments as opposed to males whom needed the assistance and advices from the herbalists.

The study wanted to establish the knowledge of community members regarding the diseases found in the community. This took into consideration the fact that health care is mainly provided by women in the community.

Mme Thantshi, a community knowledge holder, posits that:

Mo motseng wa rona, re itemogela malwetsi a a farologaneng mme ebile a le kotsi thata. Mo gare ga a mangwe, ke bona re tlhokafala thata ka ntlha ya malwetse a thobalano, jaaka Lebolela mading, bolwetse jwa sukiri, ditlhabi mo mmeleng, tlhogo e e sa feleng. Se ke malwetse ao eleng gore a tshotse maphelo a le mantsi mo motseng wa rona, segolobogolo jwang malwetsi a thobalano. Re latlhegelwa ke baswa ba le bantsi ka ntlheng ya malwetsi a.

Mme Thantshi stated that the community experiences many different illnesses, which are very fatal. Amongst others, there is a high rate of death due to sexually transmitted diseases, HIV and AIDS, diabetes, body pains, and on-going headaches. These are the diseases that took majority of loved ones from their families and friends, especially sexually transmitted diseases. Many young people pass on because of these diseases.

Moreover, Mme Mmating elaborates:

Go na le malwetsi ao e leng gore mo motseng wa rona batho ga ba bue ka one thata, ao e eleng gore le one a tsentsa letshwenyo. Malwetsi a, a akaretsa boswagadi, boo eleng gore bo tlohlwa ke fa motho wa mme kgotsa wa rre a ka tlhokafalelwa ke molekane, mme a palelwe ke go kopa thuso kwa ngakeng ya setso kgotsa mo mothong yo o nang le kitso ka ga meriane e e maleba mo bothateng jo. Moriane o o maleba fa o itsege ka leina la '*pitsa*' mme e thusa go tlhatswa madi a moswagadi go thibela gore le ene a seke a tlogela lefatshe le le ka kwano. Se ke ka ntlha ya gore madi a moswi a santse a le mo go ene, mme ke madi a a suleng, ao a tlhokang kalafi ya meriane ya setso.

Furthermore, Mme Mmating stated that, there are certain diseases in the community that are not spoken about, which are also fatal. These diseases, amongst others, include *boswagadi*, which occurs when one's partner passes away, and one fails to seek medical assistance from the THP or a knowledge holder for healing purposes. The TM needed in this case is known as '*pitsa*' which is used to cleanse one's blood to avoid death. This is because the deceased's blood is believed to be in the surviving partner's body, and since this blood is also considered dead, '*pitsa*' is needed for cleansing.

Mme Matinkane, a community knowledge holder, states:

Ke tla go bolelela ka nna, go tswa mo maitemogelong a ka ke le motho wa mosadi gore go ntse jang. Ke ne ka lwala thata, ke na le mengwaga e le masomeamabedi le botlhano, ke na le ditlhabi mo mateng aka. Mme waka yo a ntsalang o ne a lemoga fa ke na le bothata jwa popelo, mme a ntsaya, a nkisa ko ngakeng nngwe ya setso. Ke ne ka newa moriane o o bidiwang *Mothagala*, oo e leng kutu, mme kea tshwanelwa ke go o apeya, ke o bidisa thata, ebe ke o nwa ga bedi ka letsatsi, eleng phakela le maitseboa, morago ga dijo. Moriane o, o nthusitse mo go maswe tota. Bothata jwa popelo ke jone jo bo fitlhelwang thata mo basading ba motse o no, segoloboglo jang mo bathong ba baswa.

Mme Matinkane adds: I will tell you about myself, from experience as a woman. I was once very sick, when I was about your age, 25years. I could feel serious stabbing pains in my reproductive organs. My mother noticed and realised that I had a problem with my womb and she decided to take me to a THP. The THP gave me medicinal plant known as *Mothagala*, which is a root. I had to boil and cook it well, and then leave it to cool, and quickly drink it once it's cooled, twice a day, i.e. in the morning and in the evening after food. This medicinal plant helped me a lot because I never had the same problem ever again. Womb infections and illnesses are mostly prevalent, especially amongst the youth.

Mme Ngele, a THP, states:

Goya ka maitemogelo a ka jaaka ngaka ya setso kgotsa ya Setswana, ke bona baswa ba ba ntsi ba aparelwa ke bolwetse jwa tlhaloganyo, mo gare ga a mangwe, moo e leng gore ba nna le go tlhakana tlhogo, mme ba latlhelwa ke tlhaloganyo, ba iphitlhela ba sa ikitse, kgotsa ba sa itse ba malapa a bona le gore lefelo leo ba leng mo go lone ke lefe. Gantsi bolwetsi bo simolola ka bana ba bannye thata, gantsi ba dingwaga dile thataro go ya kwa godimo. Maitemogelo a, a tswa mo goreng, gantsi ke ba alafela bona bolwetsi jo. Nako nngwe bolwetsi jo bo tswa go tswa mo boloing go tswa mo direng

tša batsadi jwa bana ba, kgotsa morago ga go utlwa botlhoko mo tlhogong ka bana ke bana, ba tshameka le ba bangwe, mme ka dinako tse dingwe ba utlwisana botlhoko. Le fa go le jalo, re thusa ka mokgwa o re ka kgonang ka teng re le dingaka tša setso. Ka jalo, re ba tsenya mo dibateng, re a ba tlhapisana ka meriane ya setso, go netefatsa gore bolwetsi jo ga bo boele mo go bone, gape re ba neela meriane eo ba tshwanelwang ke go e nwa go bona kalafi. Mme gore ba bone kalafi, re dirisa meriane jaaka *Bolebatsa* kgotsa *Moologa*, mme re dirisa yone meriane e le go alafa batho ba ba setseng ba godile; eseng bana ba bannye.

Mme Ngele is a Motswana THP. From her experience as a THP, she sees a lot of young people experiencing mental illness amongst others. This is the situation whereby they become confused, lose their memories. In some cases they do not even know who they are; they do not recognise their families or their homes. Mostly, the illness is prevalent amongst small children from the age of six years and above. She had the following to say: I have noticed this because they seek help from me as their healer. Sometimes this kind of illness is caused by witchcraft, sometimes due to accidents after being hit or injured on the head. Even so, as THPs we assist as much as we can to provide to the needs of the people. When healing them, we bath them with TM to cleanse them especially in the case of witchcraft, and give them medical concoctions to drink. Medicinal plants in this case involve *Bolebatsa* or *Moologa* which are used by adults, that is, those who are twenty years and older. This is because their immune system is thought to be well developed for one to consume these medicinal herbs.

Mamello, one of the female youths in the community states:

Go na le nako nngwe e nkileng ke na le bothata jwa diphilo, go simologa ka ngwaga wa 2008 mme bothata jo bo ile jwa tswela pele dingwaga dile tharo, fa ke ne ke dira mophato wa marematlou kwa sekolong se se golo sa Moremogolo. Bolwetsi jo bo simolotse fela fa ngwaga o simologa, mme ke ne ka bona dingaka tša sekgoa mo motseng ono, mme erile ke sa nne botoka, ke ne ka fetela pele go ya go bona ngaka e nngwe ya sekgowa kwa motsesetoropong wa Mafikeng. Ka bomadimabe, le teng koo ga ke a

bona thuso. Meriane eo ke neng ke e newa e ne e fela pele ke nna botoka kgotsa ditlhabi di okobala. Ke ne ke palelwa ke go tsamaya mo sebakeng sa dikgwedi di le tharo. Legale, ke ne ka bona ngaka ya setso kwa pheleletsong gonne bolwetsi jo bo ne bo matlafala. Ngaka ya setso e ne ya nkalafa, mme ya bona fa diphilo tsa ka di na le bothata, mme a nneela moriane oo itsiweng ka leina la *Morobe*. O ne a mpolelela gore ke bidise moriane o mme ke o tlogele gore o fole, mme morago keo onwe ke khubame. Morago ga go bona ngaka ya setso, gaise ke nne le bothata jo gape. Mme go na le batho ba le bantsi mo motseng wa rona ba ba nang le bothata jo jwa diphilo, segolobogolo baswa. Bangwe ka ntlha ya go tlhoka kitso, ga ba itse le gore diphilo di fo kae mo mmeleng, mme ba tsaya gore ke mmele fela o o botlhoko.

Mamello states that she had a problem of abdominal pains in the year of her Grade12, which was in 2008, and it went on for three years. This illness started at the beginning of the year, and throughout those years she went to different western health practitioners. She even went to Mafikeng western medical doctors but she was unfortunately not getting any better. The medicine the doctor gave me gets finished while I am still in pain or having my pains reduced. I was unable to walk for three months. However, I consulted a THP in my community since my illness was now becoming worse. The THP examined me, and realised that one of my kidneys was faulty, and he gave me a medicinal plant known as *Morobe*. I was then told to boil it, leave it to cool down and then drink it while I was kneeling down like I always do when I pray at night or at church. After all this, I never had the same problem again. What is disturbing is I get to see a lot of young people of my age suffering from the same problem. Some of them do not even think it is kidney problems while some even die from it.

Through these focus group discussions and in-depth interviews with the participants, the study discovered that Coligny community is experiencing many illnesses and diseases. Many of these are quite fatal. Sadly, since this community is consisting mainly of women, they tend to be

more vulnerable to such diseases. The study discovered that internal health issues especially amongst young women, for instance womb problems, kidney failures or problems with reproductive organs is one of the major issues, coupled with HIV and AIDS. Even though HIV and AIDS cannot be cured, the in-depth interviews and direct observation proved that THPs provided TM that assist in fighting opportunistic diseases. Therefore preventing an infected person's body to become weaker. Direct observation also assisted the researcher to discover that the illnesses and diseases that the community experiences are considered to be better cured by the THPs. This is because there is never a repetition of the same problem after consulting and taking the medicinal herbs as THPs instructed.

The study discovered through direct observation that, people who bought TMs from the herbalists, especially women, knew the type of medication they needed for different ailments, and did not ask for any assistance or advice from the herbalists. However, herbalists advised first time buyers about relevant medicinal products for different illnesses. The herbalists warned them about general side effects, and consequences of over-dosing of some medicinal herbs. The herbalist continued to advise them about the importance of consuming a certain amount that is prescribed. They also emphasized on the opportunities of properly preparing these medicinal plants to avoid taking too much unnecessarily.

The study found out that there was a high demand of these medicinal plants as they were mostly used on a daily basis. It was this high demand that caused these medicinal plants to become inaccessible due to scarcity. As a result, the THPs and community knowledge holders were able to then substitute one herbal plant part with the other. For instance, they used the root instead of the branches or leaves of the same plant or used another plant altogether that performed the same purpose as the scarce one, and this was also efficient. Sunderland and Ndaye (2004) agree with the previous statement and argue that in many instances, when some of the preferred plants and plant parts become extinct, similar plants are used. Zschocke and Van Staden (2000) repeated the same opinions by supporting the mentality that leaves can be used to substitute a bark of a plant because they are equally effective.

The study is of the view that, even though there are diseases in the community that mostly affect women, the people still have a chance to be healed. This is due to the fact that these women know different medicinal plants that heal many different illnesses and diseases. This could be one of the reasons women had to be more informed and knowledgeable as far as TM is concerned. They were the victims of illnesses and diseases. Hence, they had to find ways to

heal themselves without having to travel long distances or being worried about the affordability of such medicinal herbs. This corresponds to various studies such as (Cunningham, 2001, Cocks and Moller 2002, Deiderichs, 2006) indicating females as majority users and providers of TM.

The study also noted that, perhaps substitution of plants or plant parts of the same medicinal plants could be the solution to shortage of medicinal plants, especially those that are common and heavily relied upon on a daily basis. Sunderland and Ndaye (2004) support this view and state that, it has become common in many African rural communities to substitute a certain medicinal plant with the other similar plant serving the same purpose in times of extinction or unavailability of the preferred plants. Furthermore, Zschocke and Van Staden (2000) illustrate that leaves can be used to substitute a bark of a plant because they are equally effective and serve the same purpose.

5.4. Community Members' Knowledge on Traditional Medicine

The study wanted to establish the gender distribution of respondents' knowledge about TM. This is so because in rural communities such as Coligny, females as opposed to the males hold significant indigenous knowledge and show great interest in natural resources. For instance, they use plants parts such as leaves, branches and roots for traditional healing.

It was found that the majority of females (78%) were more knowledgeable on the use of TM and its healing practices than the Male (22%). One of the reasons influencing this may be because more female are THPs, and others are knowledgeable community members than the male. This includes the gathering and preparations of these medicinal plants for healing purposes.

The study discovered through the use of focus group discussions that, community members, especially females were well informed and knowledgeable of TM both in and out of their community. They showed knowledge of diverse traditional herbs they used for medicinal purposes, through the transmission of this significant knowledge from the elderly to the young.

Nonetheless, the study also discovered through the use of focus group discussions, in-depth interviews and observations that the young are becoming more interested in the use of TM. This is mainly due to the influence from the elderly and also because they experience reduced and no side effects from these herbal plants. The youth are now acknowledging these medicinal plants and considered them to be multifunctional. Moreover, the elderly acknowledge these

herbs as they have been using them for decades and have never had a problem following the use of such herbs. Instead, these medicinal plants still continued to play a major role in their health today.

Focus group discussions, in-depth interviews and observations revealed that, more female had significant knowledge on TM as opposed to male. This is due to the fact that, more women could identify and select herbal medicines for different kinds of diseases, such as for cough, reproductive organs, ear infections and more. More women stated that they are mainly the ones who see to it that the entire household is of good health as their partners are often away from home. Though there are male THPs in Coligny community, many people preferred consulting female THPs. This exposed these health care givers to different illnesses, and enabling them to come up with new ways of traditional healing methods. Younger women also have proven to be having more knowledge with regard to TMs and their healing processes. Quite a great number of young women in the community have shown skills in the gathering, preparation, as well as the distribution of medicinal plants.

The study also discovered that more women in the study area are herbalists, proving to have more expertise on TM than men. Most males in the community admitted to having less knowledge regarding traditional medicine. They mostly referred the researcher to the women, whom they described in Setswana as *baitseanape ba kitso ya tsa setso, kalafi le meetlo* (libraries of indigenous knowledge). Observations revealed that, unlike males, females in the community who bought TM from the herbalists knew exactly the type of medicine to purchase for different ailments, without guidance from the herbalists (Monakisi, 2007). This showed improved knowledge from the community members, particularly women with regard to the use of TM and its healing practices. These women viewed traditional healing as a kind of healing that enables one's body to be strong enough to heal itself.

The study was also interested in establishing the local community health care providers. Mme Modiegi, one of the female THPs of Coligny community states:

Bongaka jwa setso, segolobogolo jang meriane ya setso, go tswa mo motseng wa rona wa Tlhabologang, oo o itsegeng thata ka Coligny, ke yone e re thusang thata ebile re e ikantseng go bona kalafi e e maleba. Meriane ya Setswana ke meriane eo e bonwang kwa nageng, e itlhogela fela ka bo yona, ebile ke meriane eo e sa tshelweng sepe sa sekgowa go e tokafatsa kgotsa go netefatsa kalafi ya manontlhotlho. Meriane ya setso e dirisiwa ke mongwe le mongwe yo o nang le kitso ya go ka e dirisa. Le fa gole jalo,

se ke se itseng ka meriane e ke gore e batla tumelo e e tseneletseng mo go yone. Ga o sena tumelo e e tseneletseng kgotsa o na le dipelaelo, meriane e e ka se go alafe. Meriane e, e dirisiwa go tlhapisa sefifi morago ga loso la mongwe mo lapeng, go alafa malwetsi, go thusa masea go gola ba itekanetse. Sekao sa meriane se akaretsa Ts'hupu ya poo, Mathunga, Mmamashi, le tse dingwe.

Mme Modiegi, a THP states that:

Coligny community members rely heavily on TM and its healing practices for various types of ailments because it provides them with satisfactory health services. These herbal medicines are found in the bush; it is not planted by any one, but grows on its own and does not need any western ingredients to be sufficient or to heal diseases effectively. TM is utilised by anyone who has the knowledge on how to use it. However, these medicinal plants are effective when the user has total confidence and faith on it. The user had to believe wholeheartedly in its healing process otherwise one would not be relieved from the ailment they suffer from. These medicinal plants are utilised to cleanse the family after the death and funeral of a loved one, or for illnesses, ensure good health for new born babies, and more. These medical plants include, amongst others, *Ts'hupu ya poo*, *Mathunga*, *Mmamashi*, *Mogato*, *Mathuba difala*, *Bolebatsa*, and *Kgare ya nche*, amongst others.

Moreover, Mme Lefika also adds:

Gantsi re dirisa meriane e go alafa malwetse a thobalano kgotsa fa motho wa monna a gobetse mo senneng sa gagwe ka ntlha ya go tsena mo thobalanong le motho wa mosadi a le mo matsatsing. Tiriso ya meriane e, e thusitse ba le bantsi mo motseng wa rona, mme e santse e thusa.

Mme Lefika claims that in many cases, most TMs that are more used in our community deal with sexually transmitted infections and diseases. Also, they heal males who got sexual illness from the sexual intercourse with a woman in menstrual periods at the time. This utilisation of TM, has, and still continues to assist many people in our community.

Rre Jimmy, a community knowledge holder, states that:

Meriane ya Setswana e mentsi ebile e farologane thata. Ebile, metse e e farologaneng e dirisa meriane e ka mekgwa e e farologaneng, ebile le maina a yona a farologana go ya ka metse ya rona kgotsa puo ya loleme. Le fa gole jalo, meriane e, e re thusa rotlhe ka mekgwa e e farologaneng. Gape, o ka fitlhela gore go na le meriane eo re sa e itseng

gajaana ebile re sa e fitlhelele ka ntlha ya tikologo ya rona, mme e kgona go fitlhelelwa kwa metseng e mengwe. Se ke ka ntlha ya tikologo ya rona, lefatshe la rona, le mofuta wa mmu o o fitlhelwang mo metseng e e farologaneng. Gantsi fa re na le mathata ka mateng a rona kgotsa re lwala re tshwerwe ke mala, re nwa *Mogato*, morago ga go bidisa moriane wa teng, o e leng kutu, mme re e bidisa gore re kgone go o nwa, go re tlhatswa mateng. Kwa metseng e mengwe o ka fitlhela *mogato* o itsege ka leina la *Mohato*, kgotsa o dirisetswa malwetsi a mangwe.

Rre Jimmy adds to what Mme Lefika has stated, and points out that, there are a lot of Setswana traditional medicinal plants which work differently because they are different. Different villages use these medicinal plants in different ways and the name given to these herbs differs according to our different languages and the villages. Even so, these medicinal plants help us in different ways. Again, you might find that there are medicinal plants that are unknown and inaccessible to us and in other villages. This is caused by the differences in the environments, and the type of the plant, and soil in these communities. Most of the time, when we have internal pains or problems, perhaps intestines, we use *Mogato*. This medicinal plant is a root, it is boiled and we drink it to cleanse our inner parts. In other villages, you might find this medicinal plant known in a different name, perhaps known as *Mohato*, or used for other illnesses as well.

Rre Oupa, who is a community Knowledge holder, adds:

Nna ka tsalo ke tswa kwa lefatsheng la Mafikeng, ke tlile ka kwano mo motseng wa Coligny ke setse ke le lesogwana, mengwaga e le mentsi e e fitileng, mme ke dula kwa metseselegaeng e e gaufi le Coligny. Ke ne ke direla basweu botshelo jwaka jotlhe, ke ba agela matlo, kgotsa ke ba agela meraka ya dikgomo tsa bona. Gonne metse ya rona e sena kalafi ya sekgowa, ebile e le kgakala thata le motsesetoropo, re godisitswe re dirisa meriane jaaka *Morobe*, *Makgolela*, le *Monnamontsu* go ikalafa nako nngwe le nngwe fa re iphitlhela re tshwerwe ke tlhogo. Meriane e, re ne re e fitlhelela mo dingakeng tsa rona tsa setso. Gonne meriane e ka boyona e le kutu, re ne re fisa kutu e, mme re goge, le go hemela mosi wa teng mo dinkong go bona pholo.

Rre Oupa adds by stating that, although he was born in Mafikeng, he moved to Coligny in his early youth a long time ago. He was working as a foreman in the farms, and also used to build houses for his employers as well as kraals for their livestock. Because his village was too far from the western medical facilities, and far from townships, he was raised by both his parents

who, at any time, used traditional medicines. This included traditional medicines such as *Morobe*, *Makgolela*, and *Monnamontsu* to relieve themselves from headaches. These medicines were accessible from the THPs. Because these medicines were roots, they were burnt, and then smoked and inhaled for healing purposes.

Tshepang, one of the young ladies in the community also states:

Ke nnete gore meriane ya Setswana e dira ditiro tse di farologaneng. Sekao, meriane e rona batho ba bomme re e dirisang fa re na le ditlhabi ka matsatsi a rona a sesadi, ke *Mosu*, *Mokgalo*, *Moselesele*, kgotsa *Mofalatsa maru*. Meriane e meraro e, e leng *Moselesele*, *Mosu* le *Mofalatsa maru* re a e kgabetlelela, re a e fisa, re be re kuelelisa mosi wa teng mo goleng botlhoko teng. Re tsaya dikala le matlhatlharapa a meriane e leng *Moselesele* le *Mosu*, fa *Mokgalo* one re tsaya kutu, eo re e tlhatlhegang, re e bidisa ebe re nwa metsi a yona. Ke meriane eo e leng gore re phela ka yona fa re le mo matsatsing a sesadi, segolobogolo fa o na le ditlhabing, mme e re thusa mo nakong e nnye fela. Mme waka ke ene o ileng a nkitsise ka ga meriane e, mme ka bona thuso e e potlakileng, mme ga ke bone nka tsamaya ke dirise meriane e mengwe go nthusa mo bolwetsing jo.

Tshepang also states that, in support of the use of TM that, it is true that Setswana TM is multi-functional. For example, the medicinal plants that you will find amongst us women are mostly *Mosu*, *Mokgalo*, *Moselesele*, and *Mofalatsa maru*, which we use, for menstrual pains. *Mosu*, *Moselesele* (which are branches and leaves) and *Mofalatsa maru* (which is the bulb) are different as they also come from different parts of a tree, but are all crushed, we also burn and expose the painful area to the smoke of these medicinal plants. However, since *Mokgalo* is a root, we chop it, put it inside the pot together with water, boil and drink it for relief. These are the Setswana TMs we trust and depend on as women and we get relief in a short period of time. I was introduced by my mother to these menstrual medicinal plants which assisted me, and I do not think I would think of trading them for anything. According to Panter-Brick and colleagues (2001), the upbringing and the verbal passing of indigenous knowledge from one generation to the other has sustained the knowledge of traditional herbal medicine to the modern scientific world of today.

The study is of the view that, TM still continues to play an important role in the lives of the people in the study area. Similarly, the majority of people in South Africa still heavily rely completely or partially on the use of TM and its healing practices. This is the medical service

system available and more accessible than the western medical service system (Shrestha, et al. 2003; Verschaeve et al. (2004). Furthermore, according to Bellakhdar (1989) the mind-set of people regarding the use of TM has changed, and therefore has encouraged research to be conducted in social behaviour which saw the need and importance of traditional medicine. This means people still have a strong belief in TM for healing purposes.

This may be caused by the significant knowledge of the community members on the use of traditional medicine. For instance, during in-depth interviews, the participants proved to have more knowledge on the time of the gathering of TM, (certain medicinal plants are harvested in the early dawn of the morning, while others are gathered at sunset). This includes different techniques of gathering, preparation and processing of these medicinal plants for healing purposes. This is because these medicinal plants may die out if they are harvested at an incorrect time or an incorrect part of the plant is harvested, or if a plant is harvested incorrectly. Cunningham (1991) agrees with this statement and states that if plants are over-harvested and incorrect methods of harvesting are used, South Africa could witness a massive implication for biological diversity. This may lead to the threat to many species, possibly extinction. Furthermore, de Wet (1993) and Diederich (2006) state that, the local use of TM, together with South Africa's richness in medicinal plants and cultural diversity makes it very important for people, especially women, to better understand the sustainability of these medicinal plants for healing purposes.

5.5. Community Members' Knowledge about the Impact of Traditional Medicine on the Environment

The study wanted to establish the gender distribution of respondents' knowledge and understanding about the impact of TM on the environment. This is because the study area has experienced an increase in population, causing increased demand on the harvesting of TM. Inappropriate and over-harvesting have been of a great concern in the community and have brought about negative implications for biological diversity. This has caused threats to many slow-growing plant species as well as the environment. The study found out that the majority of the respondents (Male= 70% and Female = 84%) were aware of the impact of TM on the environment. Focus group discussions and in-depth interviews revealed that there has been an over-harvesting of these medicinal plants by both the THPs and knowledge holders. This was compounded by drought conditions in the area and infertility of the soil. The use of in-depth interviews and focus group discussions revealed that, due to land shortage, and private land

ownership, as well as the deforestation in the bush where medicinal plants used to grow by themselves, the medicinal plants are not as accessible as they used to be due to extinction. The growing population in the study area, which leads to a high demand in housing and other basic facilities, is rapidly increasing. This puts pressure on the community to provide land to accommodate everyone. This also puts pressure on the THPs to be able to provide the health for all. This means more TM needs to be available, which may mean more medicinal informal trade has to be made to cater to the people.

This is supported Cunningham (1991), who states that, the increase in the number of people in the rural communities causes an increase in the informal trade of traditional medicinal plants. Eventually, this makes the regulation of these medicinal plants to be a critical issue. This has caused some THPs to import some medicinal plants from outside their community and from other countries to meet the medical needs of their people.

The study had to take environmental issues into consideration, and find out from the health care givers themselves, and other knowledgeable community members about the impact of TM on the environment in which they live. In this case, Mr. Davids, a male THP was interviewed, and he states:

Mo motseng wa rona, meriane ya setso eo e alafang balwetsi ba rona, ga re sa tlhole re kgona go e fitlhelela segolobologo ka ntlha ya gore naga eo re neng re fitlhelela meriane e mo go yona e tlhagotswe, mme ya tlhobololwa go aga matlo le go okeletsa baagi bodulo ka ntlha ya go tlhoka matlo le go oketsa dikolo go ruta bana ba rona. Se, ke ka ntlha ya fa motse wa rona o lemogile fa gona le tlhokego ya matlo le dikolo mo ngwageng o o fitileng. Ka mantswe a mangwe, meriane eo re fitlhelang gantsi e tswa kwa metseng le mafatshe a mangwe gonne mo gae phitlhelelo ya meriane e le e e kwa tlase thata. Re fitlhelela meriane e ka go e reka kwa mabenkeleng a dingaka tsa setso kgotsa go e reka go tswa mo go bomaitseanape ba meriane ya setso go tswa kwa Swaziland, Botswana, Limpopo, le Zimbabwe go bona kalafi e e maleba. Ka mantswe a mangwe, lefatshe leo re phelang mo go lone ga le sotlege go tswa mo phitlhelong ya meriane ya setso. Kwa ntle ga moo, bomaitseanape le dingaka tsa setso go tloga mo dinakong tse di fitileng, ba ne ba na le kitso e e tseneletseng ya go fitlhelela meriane ya kalafi ka tsela eo e sa utlwiseng lefatshe go letlelela meriane e go dula e fitlhelwa ka dinako tsotlhe.

Mr Davids, a THP in the study community, is of the view; our community no longer really caters enough TM as it used to in the past few years as a result of many developments in the community. It caused by housing and schools being built to meet the demanding needs of the community. This is due to the lack of housing and the rapid growth of the population in need of educational facilities and shelter. Our environment is not affected in any way by our gathering of the TM to heal our people. The medicine we use to heal our people is bought elsewhere from herbalists in Swaziland, Botswana and Limpopo to receive proper healing services. This is also because we run out of medicine as there is no enough land or bush for us to gather TM in our community anymore and yet the demand for TM and our service is high. Besides that, THPs have, for years, been able to gather TM without harming the environment to sustain these produce and continues accessibility.

In contrast, Mr David's brother, Mr Daniel, who is also a THP in Coligny community, also asserts:

Kwa ntle ga go sa fitlhelele meriane ya setso ka ntlha ditlhabololo tseo di leng teng mo motseng wa rona, nngwe mabaka ao a dirang gore re seke ra fitlhelela meriane ya setso ke ka ntlha ya fa naga e ntsi mo motseng wa rona e le ya Basweu mme ba e dirisetsa go jala, kgotsa yone temothuo. Basweu ba, ga ba letlelele dingaka tsa setso kgotsa baagi ba motse bao ba nang le kitso e e tseneletseng ya meriane ya setso go tsena mo dinageng tseo tsa bona go ka fitlhelela meriane ya setso go ka bona kalafi kgotsa go alafa balwetsi.

Mr Daniel, also a THP, added to what Mr Davids has said and states that, excepts for the fact that there is no more land accessibility to allow the growth of the TM due to the developments in the community, one of the reasons of the lack of TM is caused by the White farmers who do not allow us as the THPs and knowledgeable community members to access the TMs that grow in their farms. This interferes with the healing of our people, but unfortunately there is nothing else that we can do but to seek these herbal medicines elsewhere.

Mme Makoi, a community herbalist, states:

Nna meriane eo ke e rekisetsang batho ba mono gae jaaka maitseanape a meriane ya setso, ke meriane eo e leng gore gantsi ke e fitlhelela kwa nageng e e kgakajana le metsesetoropo, le motse wa rona. Ke e fitlhelela mo nageng e e magareng ga Coligny le Lichtenburg, fa e mengwe ke e fitlhelela kwa motsesetoropong wa Mafikeng, e mengwe kwa ditropong tse di kgolo jaaka Bloemfontein, le Swaziland. Tikologo ya Coligny e santse e bolokesegile, gonne ga gona pheteletso mo go kgetlheng

meriane e ya rona. Re le dingaka tsa meriane ya setso kgotsa barekisi ba yona, re na le kitso e le ntsi gore meriane e e farologaneng re e kgetlha jang gore e nne e golele go ya pele.

Mme Makoi states that the medicines she sells to the people as a knowledge holder and herbalist is herbal plants that she accesses from the bush far away from the villages and cities, far away from human interaction. I get these medicinal plants from the bush that is between Lichtenburg and Coligny, others in Mafikeng. I also get some from Bloemfontein and Swaziland. The environment of Coligny is not in any way impacted by the gathering of our medicinal plants because there is no over-gathering of these plants. As THPs and herbalists, we gather TM in such a way that they are able to grow back on their own, without damaging them or harming the environment. So our environment is still able to give us the produce we need. Van Staden (2000) agrees with this statement and claims that the strategy of substituting medicinal plant parts enables the knowledge holders to have lesser impact on the environment. This is because there is a lesser chance of over-harvesting or being involved in destructive harvesting.

Rre Senatla, a community knowledge holder posits:

Nna e le tota ke bona go sena sepe se se maswe seo dingaka tsa setso le ba bangwe ba bomaitseanape ba meriane ya setso ba se dirang mo tikologong ya rona ka go kgetlha meriane e. Se ke ka gonne re na le dingwagangwaga re ntse re fitlhelela meriane e, gonne dingaka tsa setso le bomaitseanape ba meriane ya setso ba na le tsela eo ba fitlhelelang le go kgetlha meriane e. Tikologo ya rona e santse e itekanetse, ke ka moo re nang le meriane e ele mentsi eo e tlhogang kgotsa e melang ka boyone, e sa tlhoke go jalwa ke motho. Le fa go na le diphetogo tse dintsi tse di diriwang mo motseng jaaka go aga matlo le dikolo, naga e santse e le teng eo re fitlhelelang meriane e mo go yona. Mo godimo ga moo, ga se batho botlhe ba ba itseng ka ga meriane e ya setso, ka jalo tikologo ya rona le meriane ya setso ga e mo kotsing epe.

Rre Senatla posits that there is no negative impact caused on the environment from the gathering of TM by the knowledge holders on TM. This is because as people of the community we are still able to access the same medicines that we had access to many years ago. This is mainly because our healers have different techniques of gathering medicinal plants in such a way that they are able to grow back on their own without being planted by humans. Even though there have been a few developments in terms of housing and schooling that cleared some land, there is still plenty of land left where we access our medicinal plants from.

Furthermore, since not everyone has the knowledge of TM, our medicinal plants and environment are safe and not in any kind of danger from being over-harvested.

The study is of the view that the environmental impact of gathering of medicinal plants in Coligny community has never been experienced. The THPs and the knowledgeable community members are seen as responsible gatherers of TM well informed of the methods, and periods relevant for the gathering. These indigenous people have the invaluable relationship with the environment in the same way as with the herbal medicines and respect for both. The fertility of the land and its environment is associated with harmony from the ancestors as there is a belief that the environment cannot be separated from the people and their health.

5.6. Community Members' Knowledge about the Limitations and Strengths of the Two Medical Systems

The study wanted to establish the community members' awareness on the limitations of both traditional and western medical service systems. This is because both these medical systems serve an important function to the health of the people in the study community. It was found that the majority of respondents (Male 75% and Female =80%) were aware of the limitations of western and TMs. Focus group discussions and in-depth interviews indicated the following limitations of both systems as summarized in Table 5.6.

Table 5.6 Limitations of Western and Traditional Medicines

Limitations of Western Medicines	Limitations of Traditional Medicines
Over-dosing can cause serious health issues if not death.	Not hygienic due to lack of proper packaging and processing methods.
Root-cause of the illness is mostly not considered. The focus is mainly on dealing with only the pain.	Traditional healing does not accommodate those of the foreign religions, for instance, Christianity.
Western medicine has a high rate of side effects because of the chemicals contained in the drugs.	Substitution of medicinal herbs due to scarcity of other medicinal herbs may cause complications when consumed
Not accessible to local people in the remote rural areas, because their religion and belief in ancestors are not accommodated	The preparation methods of herbal medicines takes a longer period of time.

Healing process takes a long period of time, without the guarantee that the same illness wont reappear	TM is not tested in laboratories; it is harvested in the wild, testing is done by consuming it, which might be life-threatening.
Lack of friendliness and welcoming environment. This makes people, especially women uncomfortable, thus not revealing all health problems. The rule or law of doctor-patient confidentiality is ignored by many western practitioners and there is no doctor-patient relationship established	TM lacks dosage instructions: some herbals may be life-threatening if too much is consumed.

Table 5.6 shows the limitations of traditional and western medicines. During focus group discussions and in-depth interviews, it was revealed that although western ways of healing are seen as more sophisticated, relevant, valid, hygiene, clearer in terms of dosage instructions, involve simple instructions, and are easy to consume, there are also many limitations. This medical service system involves unfriendly practitioners who do not keep patients' medical information confidential. It also involves the healing process that takes a longer period of time, and overdosing of these medicines is life-threatening. Nevertheless, it was also revealed that, most patients only walk away with painkillers, without knowing the actual cause of the illness. Also, these medicines they are given from the western facilities have unbearable side-effects. Additionally, western medicine and its healing practices divorce the cultural belief system of the people in the community.

The study further revealed through the use of focus group discussions and in-depth interviews that, western and traditional medical service systems serve the people differently, but are both considered important for healthcare purposes. They also differed in terms of accessibility, affordability, how diseases are diagnosed and treated. These differences, especially in the case of affordability and accessibility made them attract different types of customers. Most of the poor people could not afford western medicines as they were expensive. Moreover, the distance people, especially women and children had to travel to reach the modern medical services made them opt for traditional medicine. This was exacerbated by the long waiting queue to see the doctor and other services (Shrestha et al. 2003; Verschaeve et al. 2004). Madamombe (2006)

agrees with this observation and indicates that people consulted THPs due to the inefficacy of the western medical service systems.

The study wanted to establish the community members' awareness of the strength of both traditional and western medical service systems. The results are reflected in Table 5.7.

Table 5.7 Strengths of Western and Traditional Medicines

Strengths of Western Medicine	Strengths of Traditional Medicine
Dosage instructions are always given, written, explained and emphasized	Natural: no chemicals added, and reduced side effects.
Western medicines heal serious illnesses, including injuries from accidents.	Religion: it goes along with the people's African beliefs and religion, as well as their ancestors.
Thorough tests are made before the distribution of medicine to the people.	Well-known: trusted because it has been used for decades without complications.
Recognized and approved worldwide by medical and educational institutions	Accessibility: traditional healers reside in the community, making them more reachable to the people.
Prescription of medicine is simpler, and medicines are easy to use/ consume	Effective: heal faster as they are not mixed with western medicines which normally reduce its effectiveness.
Western health practitioners are professional.	Healthy: made from fresh traditional seeds, so overdosing is not harmful.

Table 5.7 presents the strengths of western and traditional medical service systems. During focus group discussions and in-depth interviews, various community knowledge holders expressed their views on the subject. For instance, Mme Sebokolodi, a community knowledge holder, states:

Goya ka nna, kalafi ya setso le yone kalafi ya sekgowa di na le makowa a tsone di le pedi. Le fa go le jalo, nako e ntsi re le baagi re lebelela sebaka seo molwetsi a lwalang ka sona, mokgwa wa kalafi le gore a re fitlhelela kalafi go tswa mo

merianeng eo re e dirisang go sa kgathalesege gore ke ya sekgowa kgotsa ya setso. Meriane ya sekgowa e kgona go alafa malwetsi a mantsi go akaretsa le go alafa motho yoo a utlwileng botlhoko go tswa mom kotsing ya sejanaga, e kgona go dira diteko tsa madi go bona malwetsi a re ka tswang re na le yone le go re alafa ka tiriso ya thekenoloji ya segompiano. Go feta moo, re bona le meriane ele mentsi ya thibela pelegi gotswa mo tirisong ya meriane ya sekgowa, mme meriane e tsaya nako e khutshwane go ka alafa. Dingaka tsa sekgowa le tsona di dira bonnete jwa gore re le balwetsi re a itse gore meriane ya rona re e dirisa ka tshwanelo. Ba dira jaana ka go re tlhalosetsa, le go re kwalela dikaelo mo merianeng gore re e dirise jang go dira bonnete jwa gore balwetsi ga ba dirise meriane go feta selekano ka ba ka nna mo kotsing kgotsa ba ipolaya ba sa ikaelela. Mme pele ba ntsha meriane e, ba dira diteko tse di tseneletseng go netefatsa gore ba neelana ka meriane e e maleba go balwetsi. Mo godimo ga moo, batho ba bantsi ba tshepa dingaka tsa sekgowa gonne meriane ya bone e isiwa ditekong pele e ka letlelelwa go ka dirisiwa ke balwetsi kgotsa go ka rekisetswa batho, mme diteko tse di diriwa ke dingaka tsa sekgowa tsa maemo a a kwa godimo.

Mme Sebokolodi states that, according to her knowledge both the traditional and western medical service systems have their weaknesses. However, even so, as the community we mostly look at the time we spend using the type of medication we choose, regardless of whether it is a traditional or western medicine. But what I will comment on is that, western medicine can cure many illnesses including illnesses or injuries caused by accidents. Also, blood tests can be done through western medical service systems to determine or diagnose our illnesses as

patients through the use of modern technology. Moreover, we are able to get contraceptives to prevent unwanted pregnancies. We can also access other medicines to prevent other diseases and infections and these medications take a shorter period of time to work or cure us. Western health practitioners also ensure that the patients understand the proper usage of the medicines given to them. Western health practitioners explain to us during consultation and by writing down some instructions on the medication itself on how the medicine should be used. This prevents the patients from under-using or overdosing themselves with the medication. Before this medication is given to us, thorough tests and diagnosis are done. This is to ensure that proper medication is given and prescribed to us as patients. Gbdossou et al. (2005) agree with the previous view, and state that western medicines are scientifically validated, hence, safe for use.

However, Mme Nnyane states that:

Le fa tiriso ya meriane ya sekgowa e kgona go alafa malwetsi ao mme Matinkane a e tlhalositseng, malwetsi ao, kgotsa ditlhabi tseo di dula di boela mo mmeleng wa motho la ntlha ya fa meriane e e okobatsa ditlhabi fela mme e sa alafe kgotsa go fedisa kutu ya ditlhabi tseo. Se ke ka ntlha ya fa batlhatlhabi kgotsa dingaka tsa meriane ya sekgowa ba lebelela ditlhabi fela le go di okobatsa, mme ba sa lebelele gore ditlhabi tseo di tswa kae kgotsa go thibela gore ditlhabi tse di seke tsa bowa. Ka gorialo, nna nkare go ya ka maitemogelo a ka jaaka moagi wa motse ono, nngwe ya makowa a meriane ya sekgowa ke gore ga e fitlhelele kalafi eo rona baagi re e labalabelang. Ke ka moo balwetsi ba nnang ba patelesega go nna ba boela kwa dingakeng tsa sekgowa kgotsa ba patelesega go ya kwa dingakeng tsa setso ka gonne ba sa fitlhelele kalafi e e maleba kwa dingakeng tsa sekgowa. Mme o fitlhela gantsi batho ba sena le bokgoni jwa go boela kwa dingakeng tsa sekgowa ka ntlha

ya go tlhoka madi. Se ke ka ntlha ya gore dingaka tsa sekgowa di bitsa madi a a kwa godimo thata go feta dingaka tsa setso. Le fa meriane ya sekgowa e isiwa ditekong ebile diteko tse di diriwa ke dingaka tsa sekgowa tsa maemo a a kwa godimo, meriane e tla e na le ditlhabi tsa yone morago ga tiriso ya yone.

However, Mme Nnyane states that, even though western medicines can cure all the illnesses Mme Sebokolodi mentioned, all these pains or illnesses keep coming back. This is because western medicines only temporarily deals with the pain, and does not target the root cause of the illness. Having said that, according to my experience and knowledge as a member of this community, one of the weaknesses of the western medical service system is that it does not cater to the full medical needs of the people. This is because the illnesses keep re-occurring even after having completed the treatment. Hence, the patients are forced to either keep going to the western health practitioners more than once or consult the THPs instead. This makes the healing process to be impossible since many of us in this community are unemployed and cannot afford to keep going back to the modern doctors as it is expensive. Be that as it may, THPs are more affordable than the western ones.

In view of the above, Muller et al. (2002) posit that, THPs are physically and geographically within reach to the people who live in villages far away from the cities, where the western facilities and medical service systems are based. Further to that, Aitken (2003) also adds by stating that the services of the THPs are more affordable for the poor and unemployed members of the rural community (Okulu, 2009; Dalmalm, 1985).

Furthermore, even though western medicines are tested and taken to laboratories for scientific processing and verifications before being distributed to the patients or being sold, they have many unbearable and dangerous side effects due to the chemicals they contain.

Dr Mahape, a western health practitioner states:

Meriane ya setso le tiriso ya yone e na le makowa a le mantsi go feta meriane ya sekgowa le tiriso ya yona. O kaya fa meriane ya setso e neelwa balwetsi ko ntle ga go netefatsa gore meriane eo e maleba go ka dirisiwa ke batho kgotsa e kotsi

mo maphelong a bona le kalafi ya bona, mme se se kotsi. Mo godimo ga moo, ga gona bonnete jwa gore meriane e ya setso ke yone e alafang balwetsi ka gore ka dinako tsotlhe ga ba boele kwa dingakeng tsa sekgowa go ba itsise gore meriane ya bona ga ya ba alafa, mme ba ne ba tshwanelwa ke go ikopanya le ngaka ya setso go bona kalafi e e maleba, eo ba neng ba e tlhoka ka nako eo. Mo godimo ga moo, dingaka tsa setso di bua maaka mo metseng ya bona ba re ba kgona go alafa malwetsi ao a tshwanang le Tuberculosis, HIV and AIDS, le a mangwe. Ba dirisa maaka go ngoka batho go itirela kgwebo, mme se ke bonokwane.

Oppositely, Dr Mahape, a western medical health practitioner, states that, TM has many weaknesses as opposed to western medicine. He argues that TM are given to people without following proper precautions to determine whether the medicines are safe to use or not, and this is a life risk. These medicines are not hygienically tested; they are just taken from the bush and given to people as raw as they are (Selby, 2009). Furthermore, there are no guarantees that these medicines are actually the ones that heal the people. For example, if a patient does not return to me and inform me that my prescriptions to them did not work and that they had to consult a THP for further medical assistance instead, I would not know if these so-called herbal medicines helped them. Moreover, as a western health practitioner, I believe in scientific verifications, so I believe these people who call themselves THPs are just deceiving the poor people just so that they can make a living for themselves. I think it has been working for them for some time now. They only attract people by lying to them, claiming that they can heal tuberculosis, HIV and AIDS amongst other diseases and this is more of a criminal act if you ask me.

Contrary to what Dr Mahape is saying above, Mr Binini, a THP in Coligny Community in contrast states:

Batho mo motseng o wa rona wa Coligny ka dumela gore ba batla thuso kwa dingakeng tsa

sekgowa. Le fa gole jalo, ba dula ba boela mo go rona dingaka tsa setso gonne ga ba bone thuse eo ba e tlhokang go tswa mo dingakeng tseo. Mo godimo ga moo, ke ne ke dirisana le ngaka e nngwe ya sekgowa go alafa molwetsi wame. Molwetsi o o ne a na le sejeso, a na le kwenanyana mo mpeng mme e dira gore a ruruge maoto, le mala a gagwe a nne botlhoko. Ka jalo, ke mo simolotse ka go mo alafa ka go dirisa meriane ya setso, e rile a nna botoka, ke fa a kgwa kwenanyana e. Ka jalo, ka tsaya kwenanyana e mme ka e isa kwa ngakeng e, mme ka mo neela molwetsi o go ka mo thusa ka meriane ya sekgowa ka mo godimo ga bolwetsi jo, o ne a an le lebolelamading. Se se thusa balwetsi go nwa meriane ya setso eo e dirang mebele ya bone gore e seke ya nna bokoa, mme masole a bone a mmele a kgone go nna le maatla, mme ba nwa le di Antiretroviral go bona bophelo. Ka gorialo, re le dingaka tsa setso re rotloetsa balwetsi go bona thusa kwa dingakeng tsa sekgoa segolobogolo jang fa ba na le lebolelamading gonne ga re na meriane eo.

Rre Binini, a THP, posits that, some people in the community do seek medical assistance from the western health practitioners. However, he argues that they always go back to the THPs as a result of continuous and constant illnesses and dissatisfaction from the western health practitioners. I worked on a patient who had something moving in her stomach, with the use of the herbal medicinal concoctions, she ended up vomiting a crocodile-like living thing and then she was healed. I took this animal to the western health practitioner for further medical examination. Moreover, since the patient was HIV positive, i advised her to seek the help of the western health practitioner, while still taking the herbal medicine I gave her. These medicinal herbs are safe to be taken with other non-indigenous medications and help in making the immune system strong to fight other opportunistic diseases. Verschaeve et al. (2004) agree

with the previous view, argue that people still partially rely on traditional medicine. This means that they also use western medicine, and mostly depend on TM as an alternative (Grierson et al. 1999) or as a supplementary to western medicine.

Mmabanyana, one of the young people in the community, when asked to comment on the weaknesses of western medical service system, she states:

Go na le na le nako eo ke ne ke ile klilining ka yone, dibeke di le pedi tse di fetileng. Ke isitse bolwetsi jwa tlhogo e e botlhoko, mme e sa fele. Fa ke fitlha ke ile ka tlhalosetsa mooki gore bothata ke tlhogo, mme a dira diteko di le mmalwa. O ne a nnaya meriane ya sekgowa, mme a re ke di nwe gararo ka letsatsi, e leng mo mesong, motshegare le maitseboa. Ke ne ka dira jalo malatsi a le mane, mme ke sa ikutlwe botoka, mme ke tlhakatlhakana ka mokgwa o mongwe. Ke ne ka tsaya leina la dipilisi tse, ka batlisisa ka ga tsone mo inthaneteng, mme ka ithuta fa ele meriane ya bolwetse jwa thobalano. Fa ke boela kwa klilining, ke botsa mooki goreng a nneile moriane kgotsa dipilisi tsa bolwetsi jwa thobalano, baoki ba bangwe ba ne ba tsena, ba mmuelela, ba re ka gongwe mooki o ne a setse a lapile, e be a dira phoso, a nnaya meriane eo ka phoso, meriane e nneng a sa tshwanela go nnaya yona.

Mmabanyana posits; I went to consult at a clinic due to an on-going headache. The medication dispensed did not help. In fact, after doing research on the medication I was given I discovered that I got the incorrect medication. In fact, the medication was for Sexually Transmitted Infections and Diseases. The western health practitioner was said to be exhausted from long working hours, and hence mistakenly gave me the incorrect medication. Whitehead (1995) agrees with this view and state that this is one of the reasons why people are afraid to consult

western health practitioners, as there is a high rate of accidental deaths due to their incompetence.

The study is of the belief that, the people in the study area are familiar with TM and its healing practices than they are with the western medical service systems. This is because TM and its healing practices have been part of their community, its culture and tradition for decades. Fabricant et al. (2001), also agree with the previous statement, and state that indigenous knowledge and the use of traditional medical service systems and healing practices have been used and completely relied upon for thousands of decades. This is the medical service system that is closely linked with their belief systems and ancestral belief. This is because the Batswana people in Coligny community still acknowledge the presence of the ancestors in their lives, and traditional healing provides a sense of relationship between them.

The study is also of the view that even though western medicinal service system is the superior healing system in the more developed areas, traditional medicinal service system is more successful in the less developed areas across Africa. Western medicinal service system has made a great impact on the modern health practices for instance; the spread of diseases, but it is unable to integrate entirely into the culture and society. Hence, traditional healing is important in traditional communities such as Coligny as part of the health care system.

One of the reasons Western methods of healing are not really working for many is the fact that medicinal facilities and hospitals are far away located from the people (Muller et al.2002). This is due to the poor transportation system, massive land and poor roads. Hence, the African people in the remote rural areas have to travel massive distance without any transportation, to get to the nearest health facilities. Due to the lack of western clinics and health facilities, these people have to wait in a long queue for hours before they could get medical attention.

Another limitation associated with western medicinal service system is the fact that even when the patients get medical assistance in clinics and other health facilities, they are not being told about the causes of the illness. Turton et al. (1993) agree with the previous view and posit that western health care practitioners do not know the causes of many diseases. Hence, they end up not having useful information on how to handle, prevent or be prepared for the illnesses. Furthermore, the technology used in western health facilities are not satisfactory, hence affects treatment as the illness cannot be clearly identified or it's caused identified earlier.

Nonetheless, African people in remote rural areas such as Coligny earn the lowest income as compared to the urban residents and therefore cannot afford western medicine as it is too costly.

This makes it difficult for the people in the rural areas to receive the service of western medicine or get proper care. The fact that western health facilities are far from the rural people's homes separate them from the most important things in their lives, such as tradition, culture, families, and are not comfortable with that. This is because western health practitioners do not take into consideration the spiritual healing that the culture of the people seeks.

CHAPTER SIX

CONCLUSIONS AND RECOMMENDATIONS

This section provides the conclusion and recommendations emanating from the research findings. These recommendations and conclusions are meant to provide information to policy makers, and other stakeholders about the challenges and opportunities provided by the two medical and health care systems.

6.1. Conclusion

The study investigated community knowledge and perceptions towards the use of traditional and western medical services in the North-West Province with special reference to the Coligny community.

The study investigated these aspects from the perspectives of the community members themselves. This included their socio-economic and demographic characteristics. These had specific cultural meanings and significance attached to the traditional medical and healing practices. These were articulated by the respondent community members in the form of narratives.

It was found that the Coligny community lacked sufficient and affordable western medical services and people had to depend on the use of TMs for healthcare services. Western medical services were not affordable and accessible to the majority of the community members. This was contributed to the high unemployment in the community. The study discovered that about 80% of respondent women were health care providers for their households and the community at large. They demonstrated wider knowledge of TM and healing practices than their male counterparts including harvesting, processing practices and processes of the TM materials harvested from the wild. This was to ensure the sustainability of the plant species and biodiversity. This included knowledge in prescribing dosage of different medicinal concoctions.

The strengths and limitations of both medical care systems were examined from the perspectives of the community members themselves.

Furthermore, the study found out that more females are dominant key knowledge holders of traditional medicine, and it's harvesting processes than males. The study revealed that the

majority of the community members, especially women depended on TM including the services of the THPs. It was found that the people were more comfortable with the THPs because they knew the community better, and understood the importance of the culture in healthcare provision compared to western/modern medical practitioners.

6.2. Recommendations

The study recommends the following:

There is a need to document the existing knowledge on TM and healing practices to ensure their protection and preservation. The Department of Health should find ways to interface western and traditional medical and health service systems to improve health care services. The Department should recognise the contributions of THPs and create synergies between these two medical service systems.

Recognising THPs and providing them with licenses to practice traditional healing could assist in establishing appropriate traditional facilities for consultation for accessible health care services.

The Department of Education should take an initiative to introduce IK, especially traditional health care practices into the school curriculum from primary school level. This could provide the younger generations with important knowledge base regarding the role of THPS as well as TM and healing practices.

More research on the challenges faced by THPs should be conducted; this is to ensure that they are taken as important contributors in community health care.

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21 October 2015

Ms Anna Hlabe 214584136
School of Social Sciences
Howard College Campus

Dear Ms Hlabe

Protocol reference number: HSS/0899/015M

Project title: Community perceptions towards the use of both Traditional and Western Medical Service Systems in Coligny Community in the North West Province (South Africa)

Full Approval – Expedited Application

In response to your application received on 10 July 2015, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol have been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh(Chair)
Humanities & Social Sciences Research Ethics Committee

/pm

cc Supervisor: Prof HO Kaya
cc. Academic Leader: Professor Sabine Marschall
cc. School Administrator: Ms Nancy Mudau

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SPEAKERS OFFICE

TO : Whom it May Concern
University of Kwazulu Natal
FROM : Mr K A Matshogo
Acting Manager office of Speaker
DATE : 19/08/2014
SUBJECT : Letter of Authorization

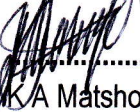
Receive Greetings,

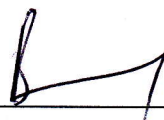
This communiqué serve here to accord **Ms Anna Hlabe student no: 214584136** with the authority to proceed doing the research for her Dissertation on : Community Perception towards the use of Traditional and Western Medical service with special reference to Coligny community in the **Ditsobotla Local Municipality (North West Province RSA).**

We further wish her luck on her task to complete the research successfully through our community support.

Hope you find this communiqué in order.

Yours Truly,


K A Matshogo


Hon: Cllr T Thamaga

Social Sciences, College of Humanities,
University of KwaZulu-Natal,
Howard Campus,

Dear Participant

INFORMED CONSENT LETTER

My name is Hlabe Anna, I am an Anthropology Masters student enrolled with the University of KwaZulu-Natal, Howard campus, South Africa. I am interested in learning about the community's knowledge and perceptions about the use of traditional and western medical service systems. Coligny community is my study area. In order for the study to be successful, I am interested in asking you a few questions if you will allow me.

- Your confidentiality is guaranteed as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- The research aims at knowing the challenges of your community relating to resource scarcity, peoples' movement, and effects on peace.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	willing	Not willing
Audio equipment		
Photographic equipment		
Video equipment		

For any enquiries, my contact details are as follows:

Email: mamy.hlabe@yahoo.com

Phone numbers: 072 109 7856

My supervisor is Prof. H.O. Kaya, who is located in IKS Centre of Excellence, University of KwaZulu-Natal, in Westville Campus.

Contact details: email: kaya@ukzn.ac.za. Phone number: 031 260 7237 / 082 857 9425

HSSREC research office contact details: Ms. P Ximba

Tel number: 031 260 3587, email address: ximba@ukzn.ac.za

Thank you for your contribution to this research.

DECLARATION

I.....(Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research project, and I consent to participating in the research project.

I understand that I am at liberty to withdraw from the project at any time, should I so desire.

SIGNATURE OF PARTICIPANT

DATE

.....

.....

**COMMUNITY PERCEPTIONS TOWARDS THE USE OF TRADITIONAL AND
WESTERN MEDICAL SERVICES WITH SPECIAL REFERENCE TO COLIGNY
COMMUNITY IN THE NORTH-WEST PROVINCE, SOUTH AFRICA**

OBSERVATION GUIDELINE

Name of the community: Coligny

Province: North West Province

Information intended to be obtained through Direct Observation

Information from Direct Observation	Method/How
General situation in and around Coligny Community Are traditional medicinal plants available and accessible in the area? Where are the people? What are their living conditions? Are they living in houses, tents or huts?	Walk and drive through the community
Condition of specific medicinal plants security-related areas What is the condition of herbal shops? What types of traditional medicines are being sold by the herbalists? Is there scarcity of traditional medicinal plants? Do people buy these medicinal herbs?	Walk and drive through the community
People's activities What are people doing? Are they working? If so, where and what? Are there many people who are not employed? Can you see many people sick people or those with injuries? Are there many people queuing? What are they queuing for?	Walk through the community, including along smaller roads and informal settlement sections
Condition of Medicinal Plants Is the soil still fertile enough to produce these medicinal plants in the future? Are some areas not harvested or are there empty fields? Do you see many dying medicinal plants?	Walk and drive through the community
Environment What damage has been caused in the environment by the harvesting of traditional medicine? Is there a lot medicinal plants? Are people burning it? Are there many trees? Are they alive or are many cut down?	Walk through the community, including the fields/bushes
Consultation of traditional health practitioners How many people consulted traditional medicine? Are they mainly children, elderly, adults or adolescents? What types of traditional medicine was commonly required by most of the people? What kind of treatment	Visit homes and workplaces of traditional health practitioners

<p>did the people seek from the traditional health practitioners?</p> <p>Condition in people's homes and presence of family members</p> <p>Are here people preparing medicinal herbs? What kind of medicinal herbs?</p> <p>How are they preparing the herbs? What fuel are they using?</p> <p>Can you see herbal and fuel stores?</p> <p>Are there many family members at home? Are they mainly children, elderly, adults or adolescents?</p> <p>What are they doing?</p> <p>Are they using traditional medicines in their homes?</p>	<p>Visit homes and property around homes</p>
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College of Humanities
Schedule of Revisions Completed Post-Examination
Masters

(Please enumerate and describe, in the form below, the concerns expressed or revisions required by the examiners as well as how the concerns/revisions were addressed/effectuated in the revised dissertation. Please add numbers if more are needed.)

Student Name: MA Hlabe

Student Number: 214584136

Degree & Programme: Master of Social Sciences (Full Research), Anthropology

Title of Thesis/Dissertation: Community Knowledge and Perceptions Towards the Use of Traditional and Western Medical Service Systems in Coligny Community in the North West Province, South Africa

#	Concern Expressed/Revision Required (verbatim, source, by whom, page reference)	My understanding of the concerns	Actions taken (detailed description, new page reference if applicable)
	Concerns: Examiner 1 (Internal)		
1	The table of contents should come before the list of tables and figures	Comment accepted	Table of contents moved to page iv; before the list of tables and figures
2	Chapter two: minor editorial please see the document; however it would be good if you can add a summary section towards the end of your chapter 2	The comment has been acknowledged.	Suitable summary has been included at the end of Chapter two, and editorial issues corrected.
3	There were references in text that were not included in the bibliography or incorrectly spelt (for example Gollinick et al. 2010 and Wooley et al. 1997).	Comment accepted.	All references appearing in the text appear in bibliography.
4	There were also a few instances of duplicated paragraphs (for example: page 18-20 Chapter2). It is suggested that the candidate ensures that all references are reflected in the bibliography appear in the document and remove duplicate paragraphs from the entire document.	Comment accepted.	Duplicated paragraphs were deleted. Also, all references that reflect in the bibliography appear in the document.
5	.		
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#	Concern Expressed/Revision Required (verbatim, source, by whom, page reference)	My understanding of the concerns	Actions taken (Detailed description, new page reference if applicable)
	Concerns: Examiner 2		
1	Strongly recommend the findings of this work to be published in a Scholarly Journal	Comment appreciated.	The work will be published as a journal article in a Special Issue/ Volume on: TOPIC of the Peer-reviewed Scientific and Research International Journal NAME OF JOURNAL AND DATE
2	The conclusion should be consolidated by using findings of the study, with some editing.	Comment accepted.	Conclusion was consolidated by using the findings of the study, with some editing.
3	It is recommended that Chapter Five and Six should be combined.	Comment not accepted.	Conclusion and Recommendations should form Chapter Six; they cannot be combined with other sections or chapters.
4	On page 18 last lines going to page 19 should be deleted. It is repetition; the same applies to page 7 the third paragraph.	Comment accepted.	The last line of page 18 going to page 19 is deleted. And the third paragraph of page 7 is also deleted.
5	Please see typing errors in the document, i.e. on pages 2, 4, 6, and 22.	Comment accepted.	Typing errors corrected.
#	Concern Expressed/Revision Required (verbatim, source, by whom, page reference)	My understanding of the concerns	Actions taken (Detailed description, new page reference if applicable)
1			
2			
3			
4			
5			

