

## TRADITIONAL HEALERS IN SWAZILAND: TOWARD IMPROVED COOPERATION BETWEEN THE TRADITIONAL AND MODERN HEALTH SECTORS

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**Abstract**—The paper describes applied research efforts, requested by the Swaziland Ministry of Health and funded by U.S. AID, aimed at providing an information base for new government policies regarding traditional healers in Swaziland. 0007957

Information reported relates to: health care manpower in the traditional sector; treatment seeking behavior in a pluralistic medical setting; traditional health beliefs and practices; payment practices; patterns of patient referral; attempts to establish an association of healers; attitudes of healers toward paraprofessional training; and possibilities for specific types of cooperation between modern and traditional health sectors. 615 0087

### INTRODUCTION AND POLICY BACKGROUND

As elsewhere in Africa, the Swaziland Ministry of Health has had an ambiguous policy or non-policy towards traditional healers. There was an attempt in 1945-1946, during the colonial administration, to pass legislation that would provide for the registration and taxation of traditional healers, and would attempt to control their activities. Prior to that time and dating back to 1894, all 'witch-doctoring' was considered illegal in Swaziland. Thus the 1945-1946 proposed legislation would have amounted to official recognition of healers on the part of the government. However, due to vigorous opposition from the then director of medical services, the legislation never went into effect.

The late King Sobhuza II was generally supportive of traditional healing. He felt that Western healing ideas and practices should not simply be accepted uncritically and adopted wholesale to the destruction of traditional Swazi ways. Instead he envisioned the development of a health care system that combined the best aspects of both traditional and modern medicines. He also believed that a scientific study of traditional healing should be undertaken before attempting to restrict or alter practices [1].

In 1954, the King issued an executive 'Order-in-Council' which represented the further development of the earlier proposed legislation. The Order dealt with registration, fee payment, referral of patients to clinics, misconduct and malpractice. Registration and taxation of healers began in the same year and records were kept by the Swazi National Council, a traditional executive body under the King.

The King called two meetings at the Royal Lobamba kraal in 1979 and 1981 to discuss the formation of a new structure to guide traditional medicine. These meetings were followed by a directive to the Ministry of Health to look into ways of organizing healers. The Minister responded by forming a Commission for Traditional Medicine whose function was to recommend ways of organizing and regulating healers. The Commission drafted revised legislation modeled upon that which applies to the modern

Medical and Dental Council. The draft dealt with registration, code of conduct, fee payment, and the formation of an association of healers. The passing of the King in 1982 interrupted the development of the Commission's activities.

In the meantime, the Ministry of Health, recognizing acute manpower shortages in the modern health sector, felt that a research report was called for focusing on manpower in the traditional health sector. Through the sponsorship of two U.S. AID supported projects, Health Planning and Management and Rural Water-Borne Disease Control, the authors were asked to consolidate their research findings and collect any further information in order to provide the Ministry with baseline data to assess the potential for improved cooperation between the government and traditional health sectors.

### METHODOLOGY

At the time of the Ministry's request, one of the authors (Green) had been engaged part-time in research focusing on Swazi traditional healers for a period of 1.5 years. Methods included participant-observation and in-depth interviews with some 20 healers and a number of their patients. To secure the information required by the Ministry, a preliminary survey was conducted between August 1982 and January 1983 with the assistance of three Swazi interviewers who were trained in open-ended interviewing. 144 healers of all major varieties were interviewed in the four major geographic regions of Swaziland: 37 in the Highveld, 36 in the Middleveld, 29 in the Lowveld and 42 in the Lubombo region. No adequate sampling frame of healers existed and thus a random or probability sample was not feasible. While the healer sample could have been more randomized by selecting only those healers who lived in randomly-selected census enumeration areas, time and effort were saved by allowing interviewers to work primarily in areas where they had kinship connections or where they had interviewed during

previous surveys. This also helped minimize suspicion and mistrust on the part of the healers.

In addition, a house-to-house census was conducted in 4 rural and 4 peri-urban communities in order to estimate the number of healers in Swaziland, along with certain of their characteristics. All households were contacted in each of the rural and urban communities [2]. A total of 598 residential units in three topographic zones were covered in the census. Due to time limitations, all peri-urban communities surveyed were in the Mbabane area. Thus there was much wider geographical coverage of households in rural areas than in peri-urban areas.

Both the survey and the census should be regarded as comprising a pilot study.

The other author (Makhubu) has spent several years analyzing traditional medicines for their pharmacological properties. She has also interviewed healers in depth on anthropological topics, and has consulted experts on Swazi law, customs and traditions.

#### VARIETIES OF HEALERS

There has been some confusion in the literature on Swaziland over the types of healers that exist. This is due partly to the common term *inyanga* which is used in both a general and specific sense; partly to changes in both healer roles and healer terms over time; and partly to the adoption of terms from other languages. There are two basic types of traditional healers in Swaziland today: the diviner-healer (*sangoma, inyanga*) and the herbalist (*lugedla, inyanga yemitsi*) [3].

Diviners work with spirits who are said to help in both diagnosis and curing. A distinction is made between ancestor spirits (*emadloti*) and spirits of foreign origin (the most prominent being *Emanzawe, Benguni* and *Tinzunzu*), yet both have beneficial functions [4]. The latter may first manifest themselves as dangerous spirits seeking vengeance for killings committed by Swazi ancestors, but they become appeased and 'domesticated' through the process of diviner training (*kutswasa*). Diviners nowadays tend to have two, three or perhaps fifteen or more spirits which guide and assist them in their healing practice. Diviners describe a division of labor between the spirits whereby each tends to have a specialized function ranging from guidance in diagnosis to help in collecting overdue patient fees.

Most diviners also treat patients with herbal and other traditional medicines (e.g. animal fats), but it is their specially cultivated relationship with spirits and their attributed divinatory power that distinguishes them from herbalists. Herbalists do not divine, although they may make diagnoses on the basis of physical or mental symptoms. They tend to be more concerned than diviners with medicines *per se* and with the functions of the human body.

Diviners are said to be called or coerced into their profession by an ancestor-sent illness believed to be untreatable by modern or traditional medicine. Submission to the calling is regarded as the only way to survive or find relief from the illness. Diviners study under an experienced diviner-teacher (*gobela*), who is usually the same person who diagnosed the mystical

illness. They study for a period of nearly 3 years and they pay a training fee of about U.S. \$200 plus one or more cows and goats. The trainee must also observe strict rules of behavior during apprenticeship, for example, abstinence from marital relations and from certain foods. Clearly, considerable sacrifice and commitment are required in order to become a diviner.

There is evidence that the training of diviners has become more institutionalized, standardized and empirically based in recent years. The current trend is for trainees to learn together in groups and to receive considerable training in herbal medicines. Previously, such healers would go off on their own for extended periods and acquire healing knowledge largely through personal visions and dreams.

Herbalists are said to choose their profession voluntarily, although a parent or other relative may make the initial decision. Of 30 herbalists who described their calling, 9 said a parent or grandparent decided to train them, 7 said they were motivated by a desire for knowledge, 5 said they were motivated by wanting to help or heal people, 5 described dreams or visions, 2 had mystical or prolonged illnesses and 2 said they were motivated by a desire to make money in a respected profession.

Over half the herbalists surveyed acquired their skills free of charge from a parent or grandparent; the remainder paid an average of U.S. \$200 for training under an experience herbalist. Apprenticeship lasted an average of 4 years in both cases.

A third type, the Zionist faith healer (*umprofeti*), arose during the development of Christian sects whose adherents reinterpreted orthodox Christianity in ways that were compatible with traditional culture. The faith healer is not a traditional healer, nevertheless he: (1) shares a common theory of health and disease with traditional healers; (2) divines in a manner roughly similar to that of diviner healers, although God or Angels are said to assist, rather than ancestor spirits; and (3) treats various illnesses, including those thought to be 'traditional' or 'African', sometimes by using herbs. However, due to their affiliation with an organized church and the fact that Zionist healing is often incidental to promulgating the faith, faith healers should perhaps be treated separately from traditional healers in matters of legislation and policy [5].

It is noteworthy that there is a certain amount of competition and mistrust among healers, especially between different types of healers. For example, diviners often say that herbalists are untrained and unguided by spirits, while herbalists claim that diviners go beyond their divining/diagnostic function in trying to cure with herbal medicines that they inadequately understand. The survey showed that while only 62% of healers engaged in any sort of mutual referrals, 98% desired a closer working relationship with doctors and nurses, and most of these were already making patient referrals to clinics.

#### NUMBER AND CHARACTERISTICS OF HEALERS

Results of the sample census indicate that there are roughly 5400 healers outside the 'modern' health sector in Swaziland. Some 50% are herbalists, 40%

are diviner-healers and 10% are Zionist faith healers; 55% of the total are male and 45% are female.

The estimates were derived in the following way: 388 homesteads, representing all the homesteads found in 4 representative rural communities, were surveyed door-to-door. A total of 32 healers were found, amounting to a healer in 8.3% of homesteads. Assuming a rural population of 500,000 and an average of 10 residents per homestead, there would be a healer in 4150 out of an estimated 50,000 rural homesteads in Swaziland.

Similarly, 210 residential units in 4 peri-urban areas around Mbabane were surveyed, 16 of which (7.6%) were found to contain healers. Assuming an 85,000 population in peri-urban areas (based on the 1976 census estimate and allowing an increase of 10,000 in 5 years) and an average of 5 residents per residential unit, then 7.6% of 1700 peri-urban units yields 1292 healers.

It should be noted that the larger interview or survey sample of 144 healers consisted of more diviners than herbalists. There were 97 diviners (67% of the total), 38 herbalists (26%) and 9 faith healers (6%). It would seem that either the census areas had an unusually high number of herbalists, or the areas chosen for interviews had a preponderance of diviners. It is also possible that the number of homesteads covered in the census were too few to allow conclusions about the relative proportion of healer types to be drawn, or that the method of locating healers for interviewing was somehow biased toward diviners. It may also be that healers were not always certain whether to call themselves diviners or herbalists since some consider themselves to be both. In any case, a larger census of healers, conducted perhaps in each sub-district of Swaziland or in a random sample of chiefs' areas, should be conducted using explicit definitions of diviner and herbalist.

There was more agreement between the two samples regarding breakdown of healer types by sex. The survey sample of healers indicated that diviners tend to be female (69%), herbalists tend to be male (82%) and faith healers are always male. The census showed that about 90% of diviners are female, 90% of herbalists are male, and 100% of faith healers are male.

#### ALTERNATIVE SYSTEMS OF HEALTH CARE

For most Swazis, illness is caused by sorcery—i.e. the deliberate use of spells and medicines for harmful purposes—or less commonly by ancestral displeasure resulting in the withdrawal of spiritual protection. The two causes are interrelated: if the ancestors withdraw their protection, a person becomes vulnerable to dangers around him, including sorcery attacks. The interpretation of illness as a disruption in social relations among and between the living and the dead is common to small-scale, traditional societies characterized by close interdependence between kinsmen and neighbors for the satisfaction of basic biological and social needs. As long as Swaziland remains a traditional agrarian society, the social theory of illness will retain its influence.

Since the introduction of allopathic or Western medicine in Swaziland, two alternative systems of

health care have developed, traditional and what we shall term modern. This has been in part the result of attempts to suppress traditional healing during the colonial period, but perhaps more importantly it can be attributed to intrinsic incompatibilities between the two health care systems and the foundations upon which they rest.

A *de facto* division of labor has developed between the two major health sectors. For most Swazis, health problems fall into three categories: those best treated by doctors, those best treated by traditional healers and those that fall in between where either type of treatment—or a combination of the two—may be effective. In the survey, traditional healers were asked to identify: (1) diseases that were best treated by traditional methods; (2) the problems or diseases that they are most commonly asked to treat; (3) the problems or diseases that they as individuals specialize in. Most frequently cited in all answers were 'African' illnesses that have a chronic or persistent nature (*likhubalo*, *umkhwabho*, *tilwane*, *tokoioshe*, *kuhabula*, *sipoliyane*), as well as the preparation of luck and fidelity medicines. Even though these illnesses may be associated with symptoms like blood in the urine, arthritic pains, diarrhea or migraine headaches, they all involve supernatural causation and are thought to be undiagnosable and untreatable by modern medicine.

Diseases designated as best treated by modern medicine include cholera, tuberculosis, heart disease, venereal disease (VD of the 'open sore' type was said to be better treated by traditional medicine) and bilharzia (if it is not thought to be *likhubalo* and therefore caused by sorcery). In a separate question on cholera, 76% of healers said that they refer patients to clinics rather than try to treat a new disease that they do not understand.

The survey revealed that doctors are much admired for certain technical capabilities as well as for the medicines they possess. Most commonly cited were various surgical practices, transfusions, and use of X-ray machines. On the other hand, diviners felt that their ability to diagnose the ultimate causes of illness (thereby answering the 'why' or 'why me' questions of misfortune) and to perform the increasingly common *femba* ceremony—both of which involve cultivated relationships with spirits—are skills that are as important as those that doctors possess.

#### HEALING PRACTICES

Swazi healing is based on a combination of naturally-derived medicines and ritual. Healers themselves emphasize medicines more than rituals. Medicines are derived from both plant and animal sources and they are prepared in a variety of ways, including boiling and burning. Preparations may be taken by a patient in a variety of ways such as vaccination, inhalation, purgative, smoke inhalation, sauna, poultice, beverage decoction, enema and snuff. Other practices such as bone-setting and 'sucking out' poison (*kumunya*) are common, as are a variety of ritual practices related to driving away spirits and neutralizing or redirecting spells. Practices may relate to preventive as well as curative health care.

The *femba* ceremony, which seems to have been borrowed (no doubt with reinterpretation) in recent historical time from groups in Mocambique, consists of drumming, singing, possession-trance, 'brushing away' of evil spirits, and physical manipulation of the patient.

Preliminary investigation of healing practices was made with a view toward possible interventions by government. That is, government could encourage practices deemed beneficial and discourage practices that may be harmful to patients. Further investigations need to be made into both healing practices and into possible options for government intervention. However, several practices can be evaluated at this point.

#### POSSIBLY HARMFUL PRACTICES

(1) Medicinal enemas (*kucutseka*) are used to prevent and treat several types of childhood diarrhea, sometimes exacerbating life-threatening conditions of dehydration.

(2) Induced vomiting (*kuhlanta*) may be dangerous for patients who have weak hearts, or for those whose lungs have been weakened by TB. Purgative herbs are sometimes used to 'clean out the chest' of TB patients.

(3) Traditional vaccination (*kugata*) is often done with an unclean razor. Razors are commonly left on the ground or floor while the medicine (*insiti*) is being rubbed into the cuts, contributing to further contamination of the razor. Tetanus and hepatitis may result.

(4) Some types of traditional medicines, such as the mind-altering *luhmane* used in psychiatric disorders, may be dangerous by themselves. Others may be dangerous if they are taken at the same time as modern medicines. Some traditional medicines used on the eyes have had unfortunate and permanent effects.

It may be premature to plan or recommend explicit government interventions, but certain relatively unobtrusive measures could be adopted at this point. For example, the Ministry could influence healers who practice vaccination to sterilize their razors properly in a flame. Or it could attempt to teach healers about the dangers of using enema to treat childhood diarrheal disease, while explaining and advocating the use of oral rehydration therapy [6].

In any case, shortcomings of traditional healing should be balanced against its beneficial or useful functions. The same can be said for modern medicine.

#### POSSIBLY BENEFICIAL PRACTICES OR USEFUL FUNCTIONS

(1) Traditional healers treat the whole person; they do not simply give medicines for particular symptoms. They know how to calm a patient's fears, explain how and why he became ill, and perhaps even make sense of his problems with neighbors and family. Reducing stress in this way is very important in treating mental illness, but it also contributes to the cure and prevention of many other types of illness.

Divining the cause of problems with bones, as well as the *femba* healing ceremony, are common methods

used by diviner-healers that are probably beneficial to at least the patient's mind by reducing fear, uncertainty and stress [7]. There would seem to be no physically harmful effects of *femba*.

(2) Some traditional medicines seem to be effective in treating certain illnesses. For example, there are medicines that may control diarrhea, sedate a patient, ease headache and other pains, and reduce swellings. Some of these medicines are currently being analyzed in order to learn more about their effects.

(3) Sometimes a patient will stay with a traditional healer for a period of days, weeks or months. This may remove the patient from a stressful situation in his family or community and help him recover.

(4) Healers may help ease pressure on overburdened clinics by treating minor, self-limiting, psychosomatic and certain other kinds of conditions in which traditional therapies are effective and appropriate. At the same time, most traditional healers recognize the superiority of modern medicine in treating illnesses such as cholera, TB, polio, bilharzia and dental problems, and they often advise patients with these problems to go to a clinic or hospital.

#### FEES PAID TO HEALERS

There has been a good deal of change in practices relating to fees in the last two or so generations. Previously, a cow was paid to a healer only after a patient had been cured, and payment established an enduring relationship between healer and patient, one that entitled the patient and members of his homestead to free treatment for subsequent illnesses [8]. There were sufficient social controls operating at the local level to ensure that the healer received his initial fee. Increased geographic mobility of healers and a transition to money as a means of payment have helped depersonalize the patient-healer relationship and have tended to make standardization of fees impossible. The fees that healers charge vary widely nowadays.

An attempt was made through the 1954 Order-In-Council to standardize the fees charged for initial diagnosis and for the *femba* curing ceremony at approx. U.S. \$2 and \$5 respectively. This has worked well enough but these fees seem to account for only a small part of a healer's income. The standardization of a rather low fee for diagnosis has possibly had the effect of predisposing healers to find complex and therefore expensive-to-treat forms of mystical illness in their patients.

It is difficult to obtain accurate information on fees, but it is clear that many healers in Swaziland have at least as many patients as physicians in private practice, and some have become quite wealthy by any standards. Patients have been observed paying between U.S. \$120-130 for treatment of a single condition such as *umtshulo*, or presumed soul loss. Healers may charge U.S. \$140 for protecting a homestead (*kubetsela*) against lightning strikes from their enemies. And following the diagnostic fee, or even in the absence of a formal diagnosis, there is a basic fee of between U.S. \$10-20 to 'open the bags' (*imvula sikhwama*), which formalizes the beginning of any sort of treatment.

The significance of such fee information lies in the light it sheds on healers' motivation. For those who would support efforts to train traditional healers as Rural Health Motivators or Nursing Assistants, it should be pointed out that most healers do not need the relatively low salaries that government employment would provide. Yet if some healers did begin to serve as health extension workers, they would doubtless expect to receive salaries from the government. This underscores the necessity of proceeding cautiously with any plans to modify the role of traditional healers.

In the absence of baseline data, it is difficult to say whether there are more healers per population now than in the past [9]. Healers themselves believe this to be the case. A quite recent development is the high density of healers in the expanding peri-urban areas. Such healers live in close proximity and scrutiny of one another, and they compete vigorously for patients. Yet there seem to be enough patients to go around and healing remains an appealing career option. Several survey respondents remarked that healing is a lucrative and respectable profession, and perhaps the best one that women and those lacking formal education can aspire to. Several respondents additionally remarked that becoming a healer helped them satisfy their thirst for knowledge and their altruistic motives.

**AN ASSOCIATION OF HEALERS**

Traditional social controls that in the past helped maintain an acceptable code of conduct among healers have been weakened by the development of labor migration, the transition to a cash economy, urbanization and other forces of social change. For example, healers in peri-urban areas may deal with a changing group of clients who themselves are temporary residents of the area. Such clients cannot exert the moral or persuasive force on a healer as could a stable, relatively unchanging group of kinsmen and neighbors.

Some years before his death, King Sobhuza II began to call for the formation of a professional association of healers, in part to re-establish social control mechanisms that could operate in a modernizing society. In response to the late King, there have been some attempts on the part of healers to organize themselves into local associations. An important motivational factor on the part of such healers seems to be the desire to dissociate themselves from the frauds, charlatans, and ritual murderers often associated in the public mind with traditional healers. At the same time, there is little tradition of formal association or even cooperation among healers in Swaziland. Therefore, some initiative on the part of people from outside the ranks of healers may be necessary in order to encourage and assist the formation of an association.

Survey results indicate that 80% of healers questioned would like to have and join a healer's association; 10% were against joining; 7% were undecided; and 2% said an association would probably not work, whatever their own feelings. Although 10% felt that jealousy, competition and mistrust among healers would doom the formation of an association, 51%

commented that an association would enable them to share their healing knowledge and learn from one another, 10% said it would increase cooperation among healers, 7% said it would help healers get to know one another better, 6% said it would help improve patient care and prevent abuse and the remaining 16% made miscellaneous favorable comments.

The authors recommend that government encourage and support the formation of a professional association of traditional healers in order to establish a continuing dialogue between healers and government, help disseminate information among and between healers, and improve the quality of healing practices. National associations of traditional healers already exist in a number of other African countries.

The formation of an association should be viewed as a way of promoting rather than directly controlling healing practices. The association would be responsible for registration, regulation of fee payment, and drawing up a code of conduct acceptable to all healers and consistent with accepted good health practices. The following chart suggests an organizational structure at local, district and national levels.

	Ministry of Health	Ministry of Home Affairs	
	National Committee of Healers		
Hhohho	Manzini	Lubombo	Shiselweni
District	District	District	District
	Local community under each chief		

This structure, which is proposed by the Commission for Traditional Medicine, established by the Ministry of Health in 1980, envisions the association as an organization to which all healers would be encouraged to belong. The proposed organization would enable healers to produce their own code of conduct, criteria for registration, and a fee-payment procedure acceptable to them. The new legislation proposed by the Commission would make possible the prosecution of those who fail to pay the prescribed fee following the accepted procedure. An association of healers should be viewed not only as a way for government to influence traditional healing but as a way to enable healers to run their own affairs in a more organized manner. The proposed composition of committees should ensure strong leadership by healers themselves with minimal government interference. The following composition is suggested:

**NATIONAL COMMITTEE**

- Healers—2 from each district
- Permanent Secretary, Ministry of Health, or representative
- Permanent Secretary, Ministry of Home Affairs, or representative
- Member of the Swazi National Council
- Registrar

**DISTRICT COMMITTEE**

- Representative from the local communities who should also choose their own chairman
- Secretary—to be appointed by the District Commissioner
- District Commissioner or his representative



## LOCAL COMMITTEE

Healers elected by their peers who reside under one chief  
 Chief's Runner  
 Chief, on voluntary basis.

The Chairman of the National Committee should be chosen by the Committee from among the healers' representatives. The Registrar, who should be appointed by the Ministries of Health and Home Affairs, should serve as secretary to the Committee.

The *inkhundla*, a recently created administrative level comprising groups of chiefs from neighboring chieftaincies, may have relevance in the future for a national healers association. For the present, the only pre-existing organization of healers are the relatively informal associations that seem to be found in most chieftaincies. Specifically, most chiefs convene occasional meetings of all healers (perhaps excepting Zionist faith healers) in order to discuss matters of interest. Many chieftaincies have representatives (*tindvuna*) of diviners and herbalists respectively who are either elected by local healers or appointed by the chiefs.

Informal networks exist among diviners, especially those who were trained by a common teacher, but these are relatively weak and comprise too few individuals to provide a basis for a national association of healers. This is especially true since roughly half of Swaziland's traditional healers are herbalists for whom informal peer networks are even more attenuated. Moreover, official or other encouragement of network-based groups might exacerbate rivalry and divisiveness that exist among and between diviners and herbalists.

Initiative for the formation of an association has already been taken by the late King and by healers themselves at local levels. The Commission for Traditional Medicine, which involves the Ministries of Health and Home Affairs, should now reconvene to consider preparing a summary of findings and proposals for the Queen Regent. Since traditional healing is intimately tied up with Swazi law and customs, further initiative from the highest level of traditional authority would be perhaps the single most important influence in the formation of a healer's association.

At the same time, local level initiatives on the part of healers must continue to be encouraged and assisted by those in government who have the requisite interest, skills and experience. The Ministries of Health and Home Affairs could identify such individuals and request their part-time participation in organizing or attending meetings of healers.

It is also at the local level that matters relating to fees and code of conduct be discussed and agreement taken through district committees to the National Committee which will help government formulate policy regarding traditional healing. Further, when the Ministry of Health or other ministry wishes to hold seminars with healers, the local committees could provide the organizational basis.

## REGISTRATION

As mentioned above, registration of healers began

during the late colonial period when it was recognized that 'modern' health care personnel would not easily displace traditional healers and the latter could not be completely ignored by the government. Registration represented a first step toward recognition of healers and exercising a modicum of control over their activities. It also provided tax revenues. Since independence, the Swazi National Council has continued to register and collect taxes from healers.

Healers themselves are favorably inclined toward registration. The survey showed that 82% of healers reported that they were currently registered, 10% were not, and 8% said they had only recently qualified and they intend to register. Even allowing for over-reporting, the proportion of healers is higher than one might expect for a traditional African society. Regarding reasons cited for registering, 30% of all healers observed that the law would support them in collecting overdue patient fees and would protect them against complaints of patients or their families. Other common remarks were that registration confers legitimacy, respectability and authority on healers, and also allows them to travel and practice healing freely throughout Swaziland and in neighboring countries.

Registration classification has in the past been on the basis of how many diseases a healer claims to be able to treat. There has been no recognition, and therefore record, of the type of healer being registered. It would seem, however, that important role distinctions that healers make among themselves should be recognized by government. Such distinctions could have policy planning implications. For example, several African governments have shown a preference for licensing herbalists rather than diviners, judging the former to be more 'scientific' [10]. While such a suggestion is not being made here, it may be that training approaches for herbalists and diviners will have to be somewhat different. And for the present, knowing the relative proportion and geographic location of practicing herbalists and diviners should give the government an idea of the nature of traditional health care, as well as changes in the system.

It would seem moreover that registration should be carried out at the local level where examination of healers' qualifications can be conducted by those familiar with them, e.g. chiefs, assistant chiefs and fellow healers. Healers practicing in peri-urban areas should still register through their own chief. Healers who are deemed to be unfit for registration should be allowed to appeal through the District Healer's Committee.

## AREAS AND EXTENT OF COOPERATION POSSIBLE

Traditional healing in Swaziland is a coherent, logically consistent system of beliefs and practices that satisfies many of the physical, mental and spiritual needs of those who participate in the system. There are over 5000 healers outside the modern health sector in Swaziland and at least 85% of the population make use of their services.

Swazi healing practices are based on a belief system of magic and religion that parallels Western science

and Christianity in its attempt to find order, regularity and simplicity in the apparent chaos and randomness of nature. Put simply, the traditional belief system provides answers to the basic questions that perplex people.

Swazi healing also has a strong empirical or naturalistic component that relates to cause and effect observations made in the everyday world. A cumulative, empirical body of knowledge relating to medicines, doses, bone setting techniques and the like is handed down to novice healers through a process of training and apprenticeship.

It might be suggested in a general way that the naturalistic or empirical part of traditional healing could be built upon by the modern health sector, since there would be common ground for understanding. At the same time there is much that is different and even incompatible between traditional and biomedical healing systems, both in underlying theory and in general practice or technique.

The authors believe that limited training of healers can be undertaken on an experimental basis. The training proposed focuses on diarrheal diseases and is outlined below. Opinions are offered in the same section on other potentially successful areas of training.

We wish to emphasize, however, that at this stage of the development of knowledge concerning Swazi healers, the Ministry of Health should tread cautiously and be very modest in its expectations. There seem to be several constraints to intersectoral cooperation, for example, a bias against traditional healers on the part of doctors and nurses as well as suspicion on the part of traditional healers regarding the motives of the Ministry of Health; yet at this stage we lack sufficient knowledge about these and other possible constraints.

When planning policies regarding traditional healers it is important to make distinction between cooperation and integration. Cooperation implies a better working relationship between the two health sectors whereby appropriate referrals between the sectors become more routine, certain of the traditional healer's skills are upgraded, and the cultural sensitivity of modern health care workers is increased. The term integration implies a fundamental alteration in both healing systems and in the roles of the respective practitioners, although in practice it is the traditional healer who is expected to change. The danger here is that the traditional healer may become a second-rate paramedical worker and thereby cease to carry out his or her important function in the local community—a function that has social, psychological and spiritual as well as bodily health dimensions. Such an outcome could be disruptive in multiple ways, including the undermining of a community's capacity to solve its own health problems [11].

At the same time, the Ministry of Health has been reluctant to identify itself in any way with traditional healers since the latter are known to engage in several practices deemed to be unacceptable by public health standards [12]. In view of this, certain governmental interventions into traditional healing seem inevitable if there is to be any sort of intersectoral association. Thus a certain amount of integration may be a *sine qua non*. Nevertheless, the authors recommend that

given our present state of knowledge and the risks involved in engineering changes in the traditional health system, the Ministry of Health should think of cooperation rather than integration as a general strategy. The recommendations made in this report aim to establish a basis for on-going cooperation. As healers begin to organize themselves into representative bodies and they begin to work more cooperatively with modern health care personnel, and after additional research findings become available, it will then be possible to revise or expand Ministry policies regarding traditional healers.

#### COOPERATION AND PARAPROFESSIONAL TRAINING

As mentioned above, 98% of healers would like better cooperation between themselves and doctors and nurses. 91% of healers surveyed specifically expressed enthusiasm for the idea of undergoing some kind of training in modern medicine. The reason most gave was that they wanted to increase their healing skills and learn more about modern medicine. However, several expressed concern that their lack of formal education would make 'communicating with doctors' difficult.

Less is known about government health sector attitudes toward traditional healers, although a preliminary survey of physician and nurse attitudes toward healers indicates considerable negative bias [13]. These attitudes must be more systematically explored and ways must be found to overcome at least some bias if intersectoral cooperation is to be successful.

Training seminars for healers is an approach that government can take even before an association of healers is formed. The Ministry of Health, through the Health Education Unit, has already planned a series of short seminars for healers in the 4 districts over the next 5 years. The first seminar occurred in June 1983. The overall objective of the seminars is the establishment of a dialogue between healers and the Ministry which focuses on priority areas of health care, viz. diarrheal diseases, childhood immunization, and maternal/child health, and which will result in a two-way exchange of information on diagnosis, treatment, disease prevention and referrals.

The authors have recommended that training be well planned in advance, focused on a very few topics and conducted in an appropriate manner whereby healers are treated in a collegial manner by seminar organizers. It is important that traditional beliefs are built upon for educational purposes and that they are not ridiculed. It is also important that training content, especially the initial stages, be of interest to healers themselves. Furthermore, there should be an initial emphasis on curative rather than preventive medicine.

As part of the seminars, healers have received training in the use of oral rehydration therapy and have been given free UNICEF packets of oral rehydration salts (ORS). While this has begun on an experimental basis, there are several reasons to believe that the program will be acceptable to healers:

(1) Healers have indicated that they would like to have a means by which they could prevent deaths of

patients with symptoms of dehydration from cholera and other diarrheal diseases;

(2) Cholera is already a disease of considerable concern among healers (and the general public) and a disease which 76% of healers surveyed admit they do not understand and do not attempt to treat;

(3) Distribution of ORS packets would constitute an important gesture of trust and cooperation on the part of the government.

(4) ORS usage does not conflict with traditional practices for treating diarrhea.

From the Ministry's point of view, diarrheal diseases constitute a high priority health concern and it is recognized that the widespread use of ORS could significantly reduce mortality (especially in infants) from these diseases.

As a result of the authors' recommendations, the Ministry has begun to train healers in ORS use on a pilot basis in selected areas. If a proposed future evaluation shows that healers are using ORS properly, it will be possible to recommend training and ORS distribution on a national basis.

Other training content planned by the Health Education Unit thus far relates to immunization against childhood diseases, maternal and child health and diarrheal diseases in general.

In a recently initiated program to train traditional healers in Ghana, training sessions were found to be more successful if topics were included that specifically related to traditional healing, e.g. how to store and preserve herbs [14]. The Health Education Unit anticipates adopting a similar strategy and has accordingly planned informal exchanges with healers to determine their training interests before finalizing training agendas.

It is recognized that healers will be more interested in curative than in preventive health care. However, traditional preventive concepts and practices (e.g. treatment of children with *tinyumatane*, a medicinal mixture that is believed to protect against lightning and various other dangers) can be built upon and some cooperation from healers can be expected in areas as childhood immunization and maternal/child health. On the other hand, judging by prevailing attitudes in Swaziland and the experience of those who have trained healers elsewhere in Africa, topics such as family planning may be of little initial interest to healers.

There is reason to believe that basic first aid would be a fruitful training topic. Healers tend to already have considerable experience in dressing wounds, setting bones, reducing pain and the like; and many patients come to healers in need of first aid. The Baphalali Red Cross has already begun first aid training for local volunteers at the community level. A comparative training program for traditional healers, geared specifically for them, could be developed, tried on a pilot basis, and then evaluated.

Although no data were collected on any interaction between Rural Health Motivators (RHM's) and traditional healers, it would seem that the two groups perform different functions and therefore have little mutual relevance. RHM's are concerned with promotive health care whereas traditional healers are concerned primarily with curative health care and

with illnesses considered 'African'. Some effort has been made to recruit healers as RHM's, but this has met with little success. The Public Health Unit is now experimenting with making RHM training sessions open to local healers who wish to upgrade their skills, yet still remain traditional healers. This approach seems much more promising.

Of course, cooperation must be two-sided. Plans will have to be developed to educate 'modern' health sector personnel about indigenous healing methods, overcoming communications difficulties, and the best strategies for cooperation. Such planning should follow a systematic assessment of government sector attitudes and perceptions.

Future research needs also include further investigation of traditional healing practices and medicines in order to guide possible government interventions; an evaluation of on-going training for healers in oral rehydration therapy in order to assess the potential health impact of such training; the identification of any traditional healing practices that could be usefully adopted by the modern health sector to improve the quality of curative or preventive health care; and further assessment of areas of possible cooperation, along with plans for initiating and implementing cooperative efforts.

It is hoped that the actions already begun by the Swaziland government will lead to sustained cooperation between modern and traditional health sectors, as has been the policy recommended for developing countries by the World Health Organization since the mid-1970s [15].

*Acknowledgements*—In August 1982, the Permanent Secretary of the Ministry of Health requested a report on traditional healers in Swaziland with a view towards assessing the areas and extent of cooperation possible between traditional healers and modern health care personnel. The request was made to the Health Planning and Management Project, which in turn requested that Drs Edward Green and Lydia Makhubu prepare a report. Both consultants were engaged in research relating to traditional healing. Dr Green is an anthropologist with the U.S. AID funded Rural Water-Borne Disease Control Project, and Dr Makhubu is a chemist and Pro-Vice-Chancellor at the University of Swaziland. The views expressed in this report are those of the authors and do not necessarily reflect Ministry policy.

#### REFERENCES

1. The information providing the basis for the foregoing derives from memoranda, correspondence, colonial administration documents and other materials found in the Swaziland National Archives, File No. 1469, Vol. 1, Witchcraft.
2. The term village has been avoided because the settlement pattern of most of rural Swaziland is one of dispersed extended- and nuclear-family homesteads. 'Rural community' is used in this paper to denote clusters of homesteads that come under the authority of a chief's assistant or a chief. Such communities have definite boundaries and are named. 'Peri-urban communities' may conform to the above model or they may more closely resemble urban neighborhoods or squatters settlements.
3. According to an observer during the 1930s, the term *lugedla* was somewhat depreciatory—even denotative of charlatans—whereas *inyanga yemitsi* had respectable connotations (Marwick B. A. *The Swazi*, p. 248. Frank Cass, London, 1940). Swazi diviners may use '*lugedla*'



- pejoratively nowadays, yet most respectable herbalists seem to identify themselves by this term and *inyanga yemitsi* seems to have fallen into relative disuse.
4. This is an apparent contrast with the Kwa Zulu in South Africa, where spirits of foreign origin appear to be associated with misfortune and social pathology. Ngubane H. The place of spirit possession in Zulu cosmology. *Religion and Social Change in Southern Africa* (Edited by Whisson M. and West M.), pp. 55-56. David Philip, Cape Town.
  5. A study of Osborne *et al.* in Botswana suggests that faith healers are less suitable than traditional healers for collaboration with modern health care personnel. Osborne O. *et al.* *Continuities Between the Practices of Traditional and Scientific Botswana Health-Care Practitioners*. African American Scholars, Washington, DC, 1977. A study of various types of healers in Mali suggests a similar conclusion for Islamic faith healers or *marabouts*. See Imperato P. J. Traditional medicine practitioners among the Bambara of Mali and their role in the modern health-care delivery system. *Rural Afr.* 26, 41-54, 1974.
  6. For an elaboration of this proposal, cf. Green E. C. Swazi beliefs and practices relating to diarrheal diseases of childhood. Swaziland Ministry of Health, 1983.
  7. Evaluations of divination can be made in terms of social rather than psychological or psychosomatic effects. For example Gluckman has noted that while a charge of sorcery may exacerbate quarrels and thereby contribute to social tension, belief in sorcery may act as a deterrent to anti-social behavior and thereby support the moral order of a community. Gluckman M. *Custom and Conflict in Africa*. Barnes & Noble, New York, 1967.
  8. Kuper H. *An African Aristocracy, Rank Among the Swazi*, p. 69. Oxford University Press, Oxford, 1947.
  9. Kuper felt that herbalists, especially those who claimed more knowledge than they actually possessed, were "definitely on the increase" in the 1930s. *Ibid.*, p. 162.
  10. Dunlop D. Alternatives to 'modern' health delivery systems in africa. *Soc. Sci. Med.* 9, 585, 1975.
  11. This point has been made by the international health specialist Carl Taylor, see: Taylor C. Implications for the delivery of health care. *Soc. Sci. Med.* 13B, 77-84, 1979.
  12. See for example, Green E. C. *op cit.*
  13. Gort E. Personal communication, 1983.
  14. Warren D. M., Bova G. S., Tregoning M. A. and Klicwer M. Ghanian national policy towards indigenous healers: the case of the Primary Health Training for Indigenous Healers (PRHETIH) Program. Paper presented to the Annual Meeting of the Society for Applied Anthropology, Edinburgh, 1981.
  15. World Health Organization, *Training and Utilization of Traditional Healers and their Collaboration with Health Care Delivery Systems*. Provisional agenda item 17. No. EB57/21 Add. 2. Fifty-seventh session of the Executive Board, Geneva.