PROSPECT AND SCOPE FOR TRADITIONAL MEDICINE IN THE SOUTH AFRICAN EDUCATION SUPPORT SERVICES

By

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DECLARATION

I declare that this dissertation:

'Prospect and scope for traditional medicine in the South African Education support services' represents my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete reference, and that it has never been submitted at another university for a degree.

.....

S.R. ZUBANE
DURBAN
JANUARY 2001

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DEDICATION

This work is dedicated to:

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SUMMARY

This research study examined the prospect and scope for traditional medicine in the South African education support services. The first aim was to assess teachers' perceptions of the need for traditional medicine practices in the school. The second aim was to investigate the problems experienced by learners which require traditional medicine practices as solutions within the school. The third aim was to determine the procedures that can be followed in order to provide traditional medicine to meet the learners' needs. The fourth aim was to provide certain guidelines regarding traditional medicine intervention within a school. The fifth aim was to find whether teachers' perceptions of traditional medicine in schools are influenced by the teachers' characteristics. Lastly, to find out whether there is any agreement among ranks assigned by the respondents to:

- job opportunities amenable to creation through the use of traditional medicine.
- afflictions amenable to treatment by traditional medicine.

A Likert scale was constructed to measure the areas indicated by the aforementioned aims of study.

The quantifying instrument was administered to a representative sample of teachers. Sixty six completed questionnaires were analysed. The Chi-square Test and frequency distribution methods were used to analyse data. The important findings revealed that teachers endorsed scale items on positive rather than negative perceptions.

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CHAPTER ONE

1.0 INTRODUCTION

1.1 MOTIVATION FOR THE STUDY

The school as a major socialising agency performs the main task of leading the not-yet-adults to responsible adulthood while they are in the process of learning and becoming. The conducive learning environment within school must be planned for, managed, assessed, and developed from time to time by the entire school community, to enable the school to excel in the execution of its duty.

It is very true that a positive learning environment has a strong impact on the behaviour of everybody within the school. It inspires everyone to strive for excellence when performing their work. The learners will be motivated to air their views and to obtain maximum academic achievement and, as a result, they will develop physically, intellectually and spiritually. This is supported by Schiro (1978:186-187) who believes that individual children learn and grow intellectually, socially, and emotionally, at their own rate and in their own style rather than in a uniform manner. The teachers will be eager to accommodate the pupils' ideas and needs so that all pupils desire to learn, and believe that what they learn is worthwhile for them. If teachers prove to be dedicated, pupils trust them with many existential problems which they know their parents cannot solve.

It is very important to know that the family shares alongside with the school in many aspects of socialization. The pupils encounter a wider circle of social interaction in the school, since they spend increasingly more years and more time in school than at home. The learners experience various types of problems in the school. As Dekker, and Van Schalkwyk (1995:22) and Lamb (1991:51) note, many educational problems which are encountered by educational institutions like schools emanate from the family, which is responsible for the primary education of the child. Since the school cannot take over completely from the family, the teachers and parents must work together to help the children with a variety of problems which affect them in the process of teaching and learning.

The literature on didactic principles, methods and strategies is quite vast (Duminy, Dreyer and Steyn, 1990; Duminy and Söhnge, 1980; Cawood and Gibbon, 1981; Behr, 1977; Van der stoep and Louw, 1987). Educators have vast knowledge of teaching skills, principles and methods because of the thorough training they receive on how they must competently do their task of teaching. They are able to identify pupils with different problems and give them assistance or call in the help of a specialist in a relevant field. If the teacher is unable to help the unfortunate learner to cope with his problems, the learner's actions can affect the teacher as well as his classmates and schoolmates, as a result, fully effective tuition will necessarily be impeded.

It is an indisputable fact that some of the problems within the schools need cultural solutions which include pupils', teachers' and parents' beliefs and patterns of behaviour.

These behaviours and beliefs are governed by cultural beliefs. Unless the provision is made for the traditional medicine in schools to assist the pupils with certain problems, some of the very good efforts which have been made to solve pupils' problems will be incomplete. The two following incidences highlight the importance of incorporating traditional medicine in the South African education support services.

According to Ngobese (1997:1) the medicine for bewitching was discovered in the classroom at Iphumuzuzulu Primary School. The school was closed for a period of three weeks because the pupils as well as teachers were ill. The parents and teachers decided to call in the help of the traditional healer of Phuthaditjhaba, from Qwa Qwa. The traditional healer used traditional medicine to cleanse the whole school at a cost of six thousand rands. Furthermore, when the writer was a schoolboy, the girls used to suffer from 'izipoliyane' (or hysteria) on many occasions. The teachers used to send the unfortunate girls home because they were unable to assist them. (References e.g. Prof. W.B. Vilakazi, 1960 published literature on Ufufunyane and Isipoliyane).

The two aforementioned incidences and many similar occurrences motivated the writer to investigate teachers' perceptions of the need for traditional medicine practices within the school. It is in the interest of the entire school community to associate traditional medicine with education for the satisfaction of pupils' needs. Consequently there is a dire need for this research to be conducted, since no study has yet been conducted to investigate traditional medicine as a part of the South African education support services.

A review on literature on South African Medical Journals (Dubovsky, 1985; Gilder, 1987; Pantanowits, 1991; Simon, 1991; Chipfakacha, 1994; Noakes, 1994; Karim, Arendse and Ziqubu-Page, 1994; Ingle, 1995; Reed, 1995; Dilrag, 1995; Lee, 1995; Crawford, 1995; Kelly, 1995; O'Mahony and Steinberg, 1995) reveals that 'natural healing' exists everywhere and in the Western world seems to be increasing in volume, and traditional healers are the most important primary health care service in African setting. What clearly comes out of this absorbing literature, is that, African researchers do see a need for collaboration between traditional healing and biomedicine, which will result in the suitable usage of various health resources. This has aroused a need in the researcher's mind to explore some ideas to find out whether traditional medicine can be instituted in education to provide for learners' needs.

1.2 STATEMENT OF THE PROBLEM

This research study is intended to meticulously identify the need for traditional medicine in education to provide for pupils' needs, and the most efficient way to follow. The South African Education system in conjunction with the South African health care system provide the biomedical service for the treatment of natural causes of illness in education. Traditional medicine for the treatment of African illnesses "izifo zabantu," resulting from natural and supernatural causes of illnesses, has not been provided for in the education system. According to Edwards, Grobelaar, Makunga, Sibaya, Nene, Kunene and Magwaza (1983:213) the indigenous supernatural concepts of illness are categorized as

magical, animistic and mystical theories; and these divisions will be discussed in the next chapter (cf. 2.9.1.5). Hence the framework for the methods and procedures for the treatment to be followed in the South African Education system must still be developed.

In this study, the problems that will be investigated pertain to the use of traditional medicine in the South African education support services, and may be formulated as follows:

1.2.1 What is the nature of teachers' perceptions of the prospect and scope of traditional medicine in the school situation?

1.2.2 Which type of illnesses do teachers believe that require traditional treatment procedures within the school?

1.2.3 What is the modus operandi that can be followed to effect traditional healing/treatment within a school?

1.2.4 Which guidelines would teachers recommend for implementation of traditional healing procedures within the school?

There are many pupils in schools who need traditional interventions because of strange happenings in certain schools linked to traditional magical, animistic and mystical theories of illness such as mass hysteria as previously mentioned, and mysterious attacks (Miya, 2000:24-25). Therefore, it is of utmost importance to draw up a plan of procedures for rendering traditional healing help to pupils, because traditional healing methods play an

important role in the treatment of illnesses perceived to be of supernatural origin (Karim, Ziqubu-Page and Arendse, 1994:3).

Karim et al., (1994:3) endevour to close the gab between the illness caused by natural and supernatural origin when they say:

> "Traditional healing does not cater for the physical condition only, but also the psychological, spiritual and social aspects of individuals, families and communities. This holistic approach to illness is the keynote of African traditional healing and much of its success can be attributed to this characteristic".

It is imperative, therefore, that the South African Education support services need to provide a plan which will enable the traditional healers to work hand in hand with other professionals and parents in order to operate effectively within the school.

The researchers have made an outstanding contributions in education about the following;

1.2.1 Provision of guidance services in schools in order to provide pupils with required skills (Botes, Gericke and Roux, 1991; Sibaya, Hlongwane, Maphumulo and Zwane, 1994).

1.2.2 Various principles and approaches of teaching and learning in order to keep the standard of education at it's maximum level through effective teaching and learning processes (Duminy, Dreyer and Steyn, 1990; Duminy and Söhnge, 1980; Behr, 1977).

1.2.3 Provision of health care services in the educational institutions with an aim of protecting the life's of the pupils from the minor and dangerous diseases; to mention a few examples (Berch, Gusson, 1970; Mellish, 1984).

Is there anything that has been done on the role of traditional medicine within the school? Therefore, we believe the information gained from this study will challenge other scholars to conduct an indepth research on the role of traditional medicine in education.

1.3 DEFINITION OF TERMS

1.3.1 TRADITIONAL MEDICINE

In this study the term traditional medicine shall mean a substance, powder or liquid used for treating diseases or for preventing illnesses.

The term traditional medicine includes a tree and its constituent parts, substance to restore health and the art of healing diseases. The various parts of the trees such as the

roots, stems, leaves, barks and flowers can be used to make medicines (Donda, 1997:1). The mixtures of fats of certain animals, such as hippopotamus, snakes, crocodiles as well as the parts of certain dead animals, such as the skin of snakes and the liver of crocodiles are used to make medicines (Donda, 1997).

The word medicine has other meanings which, however, unsuitable for the purposes of this research study.

Ngubane (1997:22) divides the concept medicine into two types; namely, medicine for healing and medicine for killing. He mentions:

> "While some medicines are always used for healing and others used for causing harm, still others can either heal or harm, depending on the motive for which they were used."

1.3.2 TRADITIONAL HEALER

In this research study the term traditional healer shall mean a person who uses herbal medicine to treat/cure African illnesses "ukufa kwabantu" based on a natural and supernatural causes of illnesses.

The traditional healer is a person who uses medicines to cure diseases caused by sorcery as well as those caused by biological factors and ecological factors (Donda, 1997:5). The traditional healer deals very largely in magic and charms. The types of traditional healers will be dealt with in chapter two.

1.3.3 THE SORCERER

In this study the term sorcerer shall mean a person who practices sorcery.

Donda (1977:4) describes the sorcerer as someone who practice witchcraft. The sorcerers can be subdivided into three sub-categories; namely: night sorcerer, day sorcerer and lineage sorcerer. These sub-categories will be discussed in the next chapter.

1.3.4 PROSPECT AND SCOPE

Prospect and scope in this research study shall mean, to examine something happening in order to find something about the processes within the limits of traditional medicine.

1.3.5 EDUCATION SUPPORT SERVICES

In this study the term education support services shall mean, all human efforts and other resources that provide assistance to individual learners, and to all aspects of the education

system. These support services try to limit and eradicate barriers to learning and development, and focus on the prevention of barriers and on the development of a supportive learning environment for all learners.

1.4 AIMS OF STUDY

This study purports to fulfill the following:

1.4.1 To assess teachers' perceptions of the need for traditional medicine practices in the school.

1.4.2 To investigate the problems experienced by learners which require traditional medicine practices as solutions within the school.

1.4.3 To determine the procedures that can be followed in order to provide traditional medicine to meet the needs of learners.

1.4.4 To provide certain guidelines regarding traditional medicine intervention within a school.

1.4.5 To find whether teachers' perceptions of traditional medicine in schools are influenced by the following teacher characteristics:

1.4.5.1 Age,

1.4.5.2 Religious affiliation,

1.4.5.3 Qualifications,

1.4.5.4 Experience,

1.4.5.5 Sex.

1.4.6 To find out whether there is any agreement among ranks assigned by the respondents to:

1.4.6.1 job opportunities amenable to creation through the use of traditional medicine.

1.4.6.2 afflictions amenable to treatment by traditional medicine.

1.5 HYPOTHESIS

This study is based on the following hypotheses:

1.5.1 Teachers do not differ with regard to:

1.5.1.1 their perceptions of the need for traditional medicine practices in schools.

1.5.1.2 their perceptions of the nature of learners' problems which require traditional medicine.

1.5.1.3 procedures to be followed in the provision of traditional medicine in schools.

1.5.1.4 the nature of methods of intervention using traditional medicine within schools.

1.5.2 There will be no association between nature of perceptions and the following teachers' biographical data:

1.5.2.1 Age,

1.5.2.2 Religion,

1.5.2.3 Qualification,

1.5.2.4 Teaching experience,

1.5.2.5 Gender.

1.5.3 There will be no correlation among ranks assigned by the teachers to:

1.5.3.1 job opportunities amenable to creation by traditional medicine.

1.5.3.2 Afflictions amenable to treatment by traditional medicine.

1.6 METHOD OF INVESTIGATION

1.6.1 THE RESEARCH PARADIGM

The research paradigm deals with the plan in which data was collected. The use was made of secondary sources such as newspapers, South African Medical Journals and books that have some bearing on the study. The research that was carried out took the form of fieldwork. The questionnaire and the interview techniques were employed as the primary tools of the study to collect data. The questions related to the problem to be investigated were prepared and handed out to the selected schools. The responses were collected for analysis.

1.6.2 THE METHOD OF SAMPLING

The researcher included certain schools in the sample, because of the formal schools established in the KwaZulu Natal Department of Education and Culture. KwaZulu Natal Province has one head office at Ulundi for the Department of Education and Culture. The Department of Education and Culture consists of eight regional offices, namely; Ulundi, Empangeni, South Durban, North Durban, Port Shepstone, Pietermaritzburg, Ladysmith and Vryheid. Within each regional office, there are district offices. Each district office has a number of circuits, and there are schools of different levels within each circuit. The circuits form clusters and a representative sample was selected from some of the schools within certain clusters.

The research sample consisted of teachers from the different school levels; that is, from grade one to grade twelve. These schools have common characteristics in the KwaZulu Natal Province as a whole. Hence, the use of cluster sampling design was suitable for this research. Ten schools were selected for this study. The respondents consisted of +100 teachers. The data on biographical variables with respect to the respondents included; age, sex, religious denomination, educational level and teaching experience.

1.6.3 THE METHOD OF DATA COLLECTION

The primary data was collected through the questionnaire techniques. The questionnaire is a prepared question form submitted to certain persons (respondents) with a view to obtain information (Van den Aardweg and Van den Aardweg, 1988:190). Questionnaires were administered to elicit information from educators. The armchair validity/content validity was used. Frankness in responding to questions was made possible by the anonymity of the questionnaire.

1.6.4 PROCEDURES FOR THE ADMINISTRATION OF THE RESEARCH INSTRUMENT AND CONTROL OF CONFOUNDING VARIABLES.

In order to administer the questionnaires to school teachers, it was required to first request permission from the Superintendent General of KwaZulu Natal Department of Education and Culture (KZNDEC). A letter was written and a copy of the preliminary questionnaires for the Superintendent General's approval was enclosed and posted. After approval was received from the Superintendent General of KZNDEC, letters to ask permission from the Chief Superintendents of the selected districts for the intended research were formulated. In each letter the school selected for the research in the circuits was identified. A copy of the letter of approval and a copy of the

questionnaire were enclosed in each letter, and were personally delivered by the researcher to the districts.

As soon as the permission was granted by the Chief Superintendents, the researcher visited the principals of the selected schools with the letters of approval from their Chief Superintendents. The arrangements for administering the questionnaire to teachers at schools were done. The researcher took precautions against the disturbing factors; such as misunderstanding of the questions by the respondents, non-completion of the questionnaire and a lower percentage of return rate of the questionnaire by the respondents. The researcher conducted a pilot study from the smaller group of the participants before the research project was conducted from the sample for the final study. The researcher explained the purpose of the research study and the questions. He also personally delivered the questionnaires to the schools and collected them again after completion.

1.6.5 PROPOSED METHOD OF DATA ANALYSIS.

The researcher made use of descriptive statistics to organize, tabulate, depict and describe, summarize and reduce mass of primary data. Inferential statistics were also applied to draw conclusions about certain measures of description of the population on the basis of a representative sample drawn from the population. Once data was collected, the questionnaires completed were coded. The coded data was submitted to the

Department of statistics at the University of Zululand in order to analyze data. The Likert scale, Chi-square Test, and frequency distribution methods of data analysis were used.

1.6.6 PLAN OF STUDY

CHAPTER ONE

Provides motivation for the study, statement of the problem, definition of terms, aims of study, hypothesis, method of investigation and a plan for the organization of the whole research report.

CHAPTER TWO

This chapter focuses on the historical background of traditional medicine. This background discusses the development of traditional medicine, the nature and role of traditional healers, traditional healing process, and faith healing in the African independent churches.

CHAPTER THREE

Chapter three deals with the traditional medicine in a changing society. The role of traditional medicine in primary health care will be discussed.

CHAPTER FOUR

The fourth chapter contains the methodology, the presentation, analysis and interpretation of data. The hypotheses will be tested.

CHAPTER FIVE

The presentation of the main findings of this investigation will be discussed as obtained from data analysis. The summary and limitations of this study and certain recommendations will be discussed.

CHAPTER TWO

2.0 THE HISTORICAL BACKGROUND OF TRADITIONAL MEDICINE

2.1 INTRODUCTION

One of the most remarkable contributions of the researcher is the compilation of the History of traditional medicine. This tremendous task has helped not only to record whatever seemed real in the life of African people, but also to bring the knowledge of traditional medicine within reach. Consequently, the present researcher is inspired by the unusual knowledge of medicine-men which has helped generations of African people.

The most outstanding in the History of traditional medicine is that, the medicine-men have remedies of real value that could be learned. As Harley (1970:14) points out that Dr Thunberg in 1780 took the trouble to identify botanically twenty-four plants used medicinally by the natives of South Africa, and was convinced of their value. That is why traditional doctors claim to be able to heal patients after physicians, have given up hope.

Our discussion in this chapter will focus on the historical background and the development of traditional medicine. A review of the nature of African religion, the nature and role of traditional healers, sorcerers, the traditional healing process and

faith healing will be examined. More importantly, the research studies which have been conducted about the traditional healing process and the newly formed African Independent Church - the National Christian Assembly of God Church, will be presented.

2.2 THE ORIGINS OF TRADITIONAL MEDICINE

The History of medicine is as old as the creation of Heaven and Earth. God Himself created everything in the world, including forests and animals which have provided healing medicines over the ages. The use of leaves to make medicine is even mentioned in the Holy Bible. Ezekial 47:12 refers to the use of leaves to make medicine when he says: "the leaf thereof for medicine". The medicine of the New Testament, for instance, with its casting out of devils, is of Mesopotamian origin.

Of all the nations of the world, the African Egyptians are the most famous to us. They are the first people who came forth and developed medicine and suggested their view as to how people can be cured in order to survive. The Egyptian Africans pondered the use of various parts of plants and dead animals to make medicines. The foundation of medicine as known to the world were laid down by Egyptian Africans (Gumede, 1990:1). Their foundation of medicine has been a source of the art of healing for mankind throughout the ages, and the fountain - head of the traditional and modern healing.

The Egyptian Africans' originality disseminated northward and southward. Since then the idea of traditional medicine spread to the African region and other countries. Bannerman, Burton and Wen-Chieh (1983:180) stress that India is one of the pioneers in the development and practice of well-documented indigenous medicine - the most notable being Ayurveda and Unani.

The development of medicine, like modern medicine, began later in Greece and other parts of the world. The Greeks started scientific medicine through the Egyptians' foundation of medicine. As Singer (1928:7) states, the Greeks derived many drugs from Egypt and others were suggested by Egyptian practice, the basis of Greek medicine, such as the forms of the surgical instruments, were of Egyptian origin.

The African Egyptians played such a vital role in giving direction to the art of healing, that no study of History of medicine dare neglect them. They were the first African people to think seriously and profoundly about medicine and delve into the art of healing.

2.3 THE DEVELOPMENT OF TRADITIONAL MEDICINE IN THE AFRICAN REGION

The gradual development of traditional medicine activities in the African region arose from Egypt, and the decision to encourage them arose from the political events of the 1960s (Bannerman et al., 1983:209). The traditional healers gained the moral support from the political authorities during the advent of freedom, as the African people rediscovered their socio-cultural identity through traditional medicine as part and parcel of their heritage. The Africans were making use of traditional medicine since the art of traditional healing was developed by the African Egyptians. Gumede (1990:7) notes that the origins of our traditional healing lie in central Africa. The economical constraints in Africa made it impossible for the introduction of modern medicine by the western countries to succeed. Hence, the use of traditional medicine activities escalated in the African region in order to improve the quality of health programmes.

African authorities established the Regional Committee for Africa to promote traditional medicine practices. According to Bannerman et al., (1983:209), the committee invited member states and the World Health Organization to take appropriate steps to ensure the use of essential drugs and medicinal plants of the traditional pharmacopoeia, so as to meet the basic needs of the communities and ensure the development of the African pharmaceutical industry. The Regional

Committee for Africa supported the traditional programme at both regional and national level of the African continent at large. Since then, the various member states are setting up a mechanism for the traditional and conventional systems to work hand in hand, and are planning to train and monitor traditional healers to enhance their performance and curtail dangerous practices.

2.3.1 THE DEVELOPMENT OF TRADITIONAL MEDICINE IN THREE PERIODS

There are three periods that can be distinguished in the development of traditional medicine (Bannerman, 1983:210-211).

2.3.1.1 PRECOLONIAL SITUATION

This was the prime period for traditional practitioners, when healers, fetishists and traditional midwives practiced their arts freely and were in any case sole guardians of the people's health. Unfortunately, very little information was recorded. Knowledge was passed on by invitation within the same family or at most within the same clan. There was no written record of the practices. The techniques of diagnosis and treatment were kept secret. The only information available comes from reports of the early missionaries and explorers.

2.3.1.2 COLONIAL PERIOD

This was marked by the introduction of the colonial powers' own civilization, religion, medicine and technology. The primary aim of this modern or western medicine was to look after the interests of colonists in the urban centres or, at most, within the area with colonialist enterprises based on agricultural or mining potential. Priority was given to the health of troops, civil servants and native labour.

During this period traditional medicine, which was repressed by the authorities, went underground. By tacit agreement, the practitioners and the users made sure that such activities went on without the knowledge of the authorities. In most countries there were, therefore, two parallel forms of medicine:

(i) an official form to which a small fraction of the population had access, and

(ii) the other used by the bulk of the population in rural areas remote from the towns.

2.3.1.3 POST COLONIAL PERIOD

The era of independence brought about a gradual change in the above situation. Traditional medicine recovered its former status in many countries and there were

several attempts to bring about recognition, official status, harmonization and collaboration. A review of the present situation has not been easy because for several countries, precise statistical data has not been compiled and analysed and the situation regarding traditional medicine is still based on conjecture. However the collection of relevant information has been initiated by a number of governments.

2.4 TRADITIONAL OR AFRICAN RELIGION

The understanding of traditional medicine lies with the knowledge of the African religion and acceptable beliefs in the traditional culture. It is therefore imperative to give a short outline of traditional religion. This will be followed by a discussion of the nature and role of traditional healers.

The traditional religion existed long before the existence of other religions on the African Continent. Peltzer (1987:49) points out that up to the first half of the 19th century, only traditional religion existed. This proves that naturally, Africans are religious people. They lived according to the Christian teaching that all men are the children of one Father Who must be worshipped, "Love your neighbour as you love yourself. Honour your parents, that your days may be long in the land which the Lord your God gives you", to mention a few examples. The fact is, the Christian teachings are exactly the same as African teachings except that the

Christian Ten Commandments are written in the Holy Bible while the African laws are in the hearts of the Africans. Any stranger is looked after because the African belief is that strangers may be messengers from God. This belief is even supported by Hebrews (13:1-2) in the Holy Bible: "Let brotherly love continue. Do not neglect to show hospitality to strangers, for thereby some have entertained angels unawares".

Ancestor worship is the dominant religion of Africans. This is the belief in human spirits who continue their life after death and still influence their living descendants. The ancestral spirits retain their human urges and want and remain in close contact with their survivors, to whom they wish to reveal themselves by means of dreams and diviners. The living must show them respect and obedience and make them sacrifices on certain occasions. Traditional religion starts at the kraal. The cattle kraal is the "African temple", where it is believed that all the ancestors have some form of contact with the living. It is here that the men discuss important matters. Here too, the deceased kraal headman was buried, usually after sunset. The kraal head takes the lead when the ancestral spirits are invoked at certain times. Beasts are killed for sacrifice in the cattle kraal. Cattle are of ritual value, because they afford an important means of communication with the ancestral spirits.

The dead have influence on the lives of their own descendants only. None but their own descendants need pay any attention to them. That is why it is most essential for a person to have ancestors in the male line. Without these, he would be forgotten and forsaken after death. In practice people occupy themselves chiefly with the spirits of ancestors recently dead and well remembered. Consequently the group that usually takes part in ancestral rites is the family group with a common patrilineal grandfather or great - grandfather. The head of the family is obeyed by all people within the family and he should obey the ancestors and know all the customs and norms of the family.

The majority of Africans are staunch believers in ancestral worship and honour their dead by burying them within the premises of their homes. They believe families and relatives who have shared their homes deserve to be buried where they lived, not in some remote, impersonal cemeteries. Since Africans spend a lot of time communicating with their ancestors to seek advice, guidance and powers, they feel it makes more sense to bury them where that advice is more accessible. They are following the long tradition of being close to their dead both physically and spiritually. This custom is of utmost importance because every time the head of the family wants to talk to his father he does not have to go to the graveyard. Even during ancestor worship, people pray to their own 'honourable' ancestors. Sometimes the ancestors are thanked, and the rituals are performed which are intended to link the living members of the family with the dead. That's

why Africans want to cling to their culture and tradition because this is one thing that makes them Africans. Since times have changed, and the majority of Africans live in urban areas and suburbs, they are at liberty to bury families and relatives in cemeteries. But some of the Africans still take bodies back to their place of origin in the rural areas and bury them within the premises of their homes.

Although the traditional religion of the Africans is in the main an ancestral cult. However, above everything else, they believe in a High God, UMvelingqangi, who is superior to all other beings. He is believed to be the Creator of all things and the final arbiter of human destiny. He is, however, represented as Being too remote to be directly approached by the living. Ancestral spirits are sometimes asked to intercede with Him on behalf of the living.

2.5 THE NATURE AND ROLE OF TRADITIONAL HEALERS

As in modern societies, where there is a variety of types of modern practitioners with various specialties, namely; urologists, paediatricians, obstetricians and gynaecologists, to mention a few examples, in traditional societies a variety of types of traditional curers with different expertise are usually found.

There are traditional healers who possess magical powers, and others are supernaturally endowed curers. Whatever the source of power, the primary role of traditional curers is to identify the cause of the illness, and then to determine how to cure and overcome the illness. The natural causes of illnesses are treated in non-magical and non-religious fashions.

The major role played by traditional healers is the treatment of *ukufa kwabantu*, 'the disease of the African peoples' as stated by Ngubane (1977:15). Some of these mysterious diseases, as classified by Donda (1997:21) and Sokhela, Edwards and Makhunga (1982:82) are:

Izipoliyane - it is a disease of the girls caused by the so-called iziphonso, 'medicines thrown at the people by the sorcerers'.

Isihwane - when there is an animal who kicks family members to death and this animal is invisible.

Umeqo - a harmful medicine placed on a pathway by a sorcerer to harm somebody.

Idliso - a disease caused by noxious medicines added into the food by the sorcerer.

Umnyama - is understood as a mystical force which creates suffering of any kind such as poverty, misfortune (amashwa), and repulsiveness (isidina) whereby the people around someone (patient) hate him or her without any valid reasons.

Ubundiki - is conceptualised as an animistic force which makes a person (patient) to behave as if he is mad, it is believed he is possessed by the spirit.

2.6 THE TYPES OF TRADITIONAL HEALERS

We can identify four types of traditional healers. Each traditional healer has distinctive features, and the extent of traditional healers use of medicinal plants varies. Edwards (1986:1273) and Karim et al., (1994:7) mention three main types of traditional healers. Karim et al., (1994:8) also gives the traditional birth attendant as the fourth type of traditional healers in addition to the aforementioned.

2.6.1 INYANGA 'TRADITIONAL PRACTITIONER'

The medicine man, traditional doctor or traditional practitioner among the Zulus is called an *Inyanga*. In Xhosa the medicine man is called *Inyangi* or *iXhwele*. Generally, there are more medicine men as compared to medicine women.

Inyanga is a personage who enjoys the prestige and a high reputation of being the real practitioner of traditional medicine. Inyanga is a specialist in the use of Herbal medicine because he has a vast knowledge of curative herbs, natural treatments and medicinal mixtures of fats of certain animals as well as the parts of certain dead animals. He or she has a broad curative expertise in preventive and

prophylactic treatment, rituals and symbolism as well as preparations for luck and fidelity. There are medicine men who treat only one disease and become famous specialists on that disease. These include military doctors of war, rain-making doctors and specialists in diseases of specific organs, for example; heart, kidney or lung disease consultants (Karim et al., 1994:7). Donda (1997:44) distinguishes four types of *izinyanga*:

2.6.1.1 AMAXHWELE 'VILLAGERS'

Amaxhwele are the members of the community who themselves gather and administer certain herbal remedies for common ailments. Included in this group are *omamezala* 'mothers in law' and *ogogo* 'grandmothers' who take charge of their daughters in law's babies from birth, gathering herbs, preparing and administering purges deemed necessary for the cleansing of the newly born child from impurities passed on by the mother.

2.6.1.2 OCHITHA 'HERBAL VENDORS'

The Herbal Vendors gather and sell herbs and bark for various ailments but do not diagnose illnesses. Their children frequently gather herbs with them and grow up well informed about the plant lore of the community.

2.6.1.3 IZINGEDLA 'TRADITIONAL HEALERS'

These traditional doctors heal and provide protective charms against evil such as '*ukubethela* and *ukucupha*'. They treat diseases with various herbal remedies including *izinyamazane* 'dried and powdered parts of animals'.

2.6.1.4 IZINYANGA EZIXUBE NOLWAZI LWABELUNGU 'HOMEOPATHIC HERBALISTS'

These doctors undergo training. They are trained in the various medical colleges such as Medunsa, University of Natal Medical School; to mention a few examples. The duration of training is seven years. The medical schools admit applicants who have obtained aggregate symbols A, B and C with full exemption certificate in grade twelve. These applicants must have passed Mathematics as well as Physical Science and Biology with good symbols at a higher grade level. The homeopathic herbalists do consult the ancestors. They use various learned methods of homeopathic diagnosis and homeopathic medicines. The fact that not anyone could become a homeopath is highlighted by Msimang (1975:317) when he says: "It was not up to every Tom, Dick and Harry to carry the bags and cure the diseases, but only those who are controlled by the ancestral spirits".

2.6.2 ISANGOMA 'TRADITIONAL DIVINER'

Isangoma is commonly known as *igqira* in Xhosa. *Isangoma* is a traditional diviner who has received the gift from ancestral spirits to know and reveal the causes of diseases. The traditional diviner describes exactly the nature of illness and also divines the causes of the illness in terms of African concepts. Most traditional diviners are usually women although the calling is open to both sex. They may or may not have knowledge of herbal medicine and medicinal mixtures of fats and parts of animals. The traditional diviners utilise supernatural powers of diagnosis. Donda (1997:5) divides traditional diviners into three sub-categories:

2.6.2.1 ISANGOMA SEKHANDA 'HEAD DIVINER'

When this type of diviner divines the devotees lead him to the correct answer by admitting loudly when he is close to the truth, but softly when he is far away from the truth. Ritter (1955:390) sees this method of divining as mere guess work: "Chanting his questions, the diviner will require his audience to reply, everyone of them, '*siyavuma*' - we agree. This emphasis or lack of emphasis would then guide him to give his answer or divination, which was always clothed in self-evident ambiguity like the Oracle of Delphi".

2.6.2.2 ISANGOMA ESICHITHA AMATHAMBO 'BONE THROWER'

This is a learnt art. The configuration of the bones tells him the unknown secrets of the diseases.

2.6.2.3 UMLOZI 'WHISTLING DIVINER'

The spirits communicate directly with the client in a whistling style. Ritter (1955:391) elaborates on this type of diviner in the following way:

"This type is a ventriloquist, and usually only divines in a hut filled with acrid smoke. Different 'spirit' voices will come from the roof and sides of the hut and from the very ground itself".

The term *umlozi* means 'a whistle'. *Umlozi* is also known as *ikhwela*. This type of diviner uses *ikhwela* to answer the spirits if needed.

2.6.3 UMTHANDAZI OR UMPROFETHI 'PROPHET'

The faith healer or prophet, (muProfiti as called by the Sotho people) is a person who has power to eliminate the evil spirits through exorcism, from a person or place through prayer. God Himself provides the healing power. Edwards et al.,

(1983:214) state that the advent of the Umthandazi can be seen as an outgrowth of the influence of urbanization, acculturation, Christianity, and the African independent movement. The African independent church movement broke away from the more Western oriented missionary churches (Edwards, 1986:1273). Hence, *Umthandazi* is a professed Christian who belongs to one of the missions of African independent churches. He or she is the most potent expeller of evil spirits.

It has been argued that many of the cultural healer roles of the isangoma have been taken over by umthandazi within a modern supernatural religious; for example, Christian framework and urban setting (Edwards, 1986:1273). This is an indisputable fact because the doctrines used seem to integrate both Christian and African traditional beliefs. The faith healer and the traditional diviner both concentrate on the personal causation of illnesses. They usually see the personal causation of sickness in terms of the following conflict situations; firstly, an enemy wrongfully, with or without the assistance of a bad spirit, causes sickness of death, and secondly, the evil spirit of a deceased acts against the wishes of a person.

Since the traditional healers are an integral part of all African cultures and communities, they are able to treat both the natural and the supernatural causes of illnesses. The supernatural causes of illnesses cannot be treated by modern

doctors. The nature of these illnesses is based on the African cosmology. Traditional healers are able to cure the supernatural causes of diseases using traditional methods of healing. The traditional curers protect people and their surrounding from sorcery. They also treat "ukufa kwabantu" which is caused by different sorcerers.

2.7 THE TYPES OF SORCERERS

Ngubane (1977:31) distinguishes three types of sorcerers:

2.7.1 NIGHT SORCERER (UMTHAKATHI)

The night sorcerer is known as "umthakathi wasebusuku" in Zulu. He is always a man. The Zulu people believe that the night sorcerer was 'created or moulded with an evil heart'. He harms people for no reason. The night sorcerer keeps baboons as companions and is said to ride them at night facing backwards when visiting homesteads to perform his evil acts. He digs up corpses, resurrects them to become zombies or dwarfs (*imikhovu*) who are under his command. The night sorcerer also keeps cat familiars (*izimpaka*) and snakes which he uses to trouble the community as a whole. He places harmful medicines *(umeqo)* at the gates and doors of the people's houses. The night sorcerers are always men who are

engaged in these practices, and they always work during the night under the cover of darkness.

2.7.2 DAY SORCERER

The day sorcerer (*umthakathi wasemini in Zulu*) only operates during daytime. The day sorcerers are usually both males and females, but women outnumber men. They only act against their enemies. The sorcerers pour poison or noxious medicines on the victim's path *(umeqo)*. Day sorcery takes place in situations rife with competition, jealousy and rivalry.

2.7.3 LINEAGE SORCERER

The lineage sorcerer is commonly known as "*umthakathi wozalo*". This person bewitches the members of his own family. He churns "black medicines" (*uphehla amanzi amnyama*) and causes the ancestral spirits to trouble the members of the family (*aphendule idlozi*). The lineage sorcerer would, for instance, send a hairy dwarf (*utokoloshe*) to sleep with members of the family in order to cause impotence among them. He knows that impotency will deprive them of children and since they will have no heirs he will be entitled to collect their possessions after their deaths. This type of sorcery (*ubuthakathi*) is practiced by men only.

2.8 THE TRADITIONAL AND FAITH HEALING

2.8.1 THE TRADITIONAL HEALING PROCESS

The bases of traditional healing practices are cultural beliefs which have existed for several centuries on the African continent, before the new development of modern scientific healing activities. These traditional activities differ among various African countries because of their cultural beliefs, customs values and norms.

The African cultural religion plays a vital role in the whole traditional healing process. The traditional healing is intertwined with African religion and cultural beliefs. Hence, it is of utmost importance to bear in mind that any form of healing process that disregards the African religion and cultural belief is completely not acceptable to traditional communities. Karim et al., (1994:4) make this assertion very clear when they point out and emphasize that:

> "to understand the African traditional healer and the whole traditional healing process one needs to understand African religion. The whole African belief system is so fundamental that any form of healing process that ignores these beliefs is psychologically unsatisfactory and in some cases unacceptable. It is the only coherent system

that has maintained the social equilibrium of the African peoples for generations."

The traditional healing process is based on superstition, with deep-rooted traditions which make no room for modern medicine. The traditional healers commonly share traditional beliefs and practices with their patients. There is absolutely no cultural difference between traditional healers and patients. The traditional curers provide culturally familiar methods of explaining the causation of illness and its relationship to the people's social and supernatural worlds.

Upon the diagnosis of the illness, the traditional doctor (*inyanga*) and the traditional diviner (*isangoma*) find the origin of the disease in the disturbed communal society. They recognize the bedevilling effect of the powers unleashed in the inter-human relationships and the threatening support of the spirits, and stave off these powers differently. The traditional practitioner and the traditional diviner seek for a solution which accedes to the conditions of the spirits. They are concerned about the restoration of the disrupted social relations. The traditional doctor and the traditional diviner advocates ancestral worship and the expulsion of evil witchcraft powers through rites of a magic nature. They are able to identify the causes and existence of illnesses (*izifo zabantu*) that the modern practitioners deny and then administer the traditional medicine. The ill-health believed to have natural causes are handled in non-magical and non-religious fashions.

The holistic approach is used by the traditional curers in the healing process whereby the patient, his entire family and their environment, that is; the house(s) and the yard undergo the treatment. According to the traditional practitioners, this is the best way to remove completely the evil spirits that cause illness. The healing process is facilitated by the broader involvement of members of the family. This is well supported by Karim et al., (1994:4) who state that traditional healers are known to treat the whole person, paying attention to family and social relationships as these may influence or be influenced by the person's malady.

2.8.2 FAITH OR PROPHETIC HEALING IN THE AFRICAN INDEPENDENT CHURCHES

Much has been written in the Holy Bible about faith healing as part of the functions of Jesus Christ. "Behold, I will bring to it health and healing and I will heal them and reveal to them abundance of prosperity and security" (Jeremiah 33:6). Jesus Christ went about all Galilee, teaching in their synagogues and preaching the Gospel of the Kingdom, and healing every disease and every infirmity among the people. So His fame spread throughout all Syria, and they brought Him all the sick, those afflicted with various diseases and pains, demoniacs, epileptics and paralytics, and He healed them (Matthew 4:23,24). "Jesus Christ also gave His twelve Disciples and Prophets the Power to heal the

sick, raise the death, cleanse lepers, cast out demons, without payment as they had received the power of healing free" (Matthew 5:8).

The Holy Bible's viewpoint of the power of healing is not different from the healing practices we find in the African Independent Churches. The African Indigenous Churches engage in healing activities in their church services, whereas the healing practices have been overlooked in the western-oriented churches. Many Africans found conversion to African Independent Churches attractive than conversion to Christian Churches, since in African churches serious attention is given to the traditional healing of diseases related to the African cosmology, which includes sorcery, witchcraft and spirit possession, and they also put more emphasis on cleansing, purification and restoring of relationships. Hence, most elements of traditional religion are maintained. According to Denis (1995:103), the African Indigenous Churches are overwhelmed by the members of the western-oriented churches who seek assistance from them with regard to their healing procedures. They associate themselves with the African Independent Churches and even officiate as Prophets and Faith-healers. The office of prophet/prayer healer in the African Independent Churches fulfils a much felt need because of the traditional society's age-old role of the diviner and herbalist, for which the missionary or pastor in Christianity had no substitute (Oosthuizen, Edwards, Wessels, and Hexham, 1989:75).

The prophetic doctrine completely forbids any form of ancestral worship. The prophets' therapy is based on a belief in the power of the Christian God, which surpasses all other powers. They eliminate the evil spirits through exorcism. The objects used by prophets during exorcism are primarily the visual symbolic concretization of the Divine Power, which in itself has no dedicative effect. The faith healers do not only prescribe symbolic exorcistic treatment, but also suggest that there must be confidence in the man of God who will provide succour. Gold Himself is the '*Supplier of curative Power*'. Furthermore, the prophets emphasizes the need for earnest and forceful prayer. They also stress the importance of the individual's faith. The faith healers' secret is precisely in the healing wonders of God. The strength of God cures the patients who cannot even be healed in hospitals, clinics, private doctors, or by traditional doctors and traditional diviners.

The faith-healers and prophets make use of some of the methods of healing that were used by Jesus Christ Himself, namely; speech, praying for the patients, touching the patients and using something to effect the cure. In many cases, the prophets and faith-healers are more flexible. Many of them use western medicine as well as their own techniques of healing. They are able to assist in handling what their patients might regard as African complaints. In this regard, of course, prophets and faith-healers claim to be able to cure a far wider range of complaints than do Western doctors. Hence, they are the providers of the preventive community

psychology which is traditionally aimed at protecting the individual, family and community against all the forces of sorcery, witchcraft, jealousy and conflict (Edwards, Makunga and Nzima 1997:4).

The African Independent church healing techniques appeal to many Africans because of the ways in which they establish rapport with the patients in ways that Western medicine does not (Oosthuizen et al; 1989:69). They base their healing activities on charismatic and indigenous procedures in which the faith-healers and prophets play the most important role. Whenever there is an outbreak of spirit possession in homes and educational institutions, the ministers who are prophets and faith-healers from the African Indigenous Churches are called for assistance. The researcher happened to observe the process of exorcism which took place at Adams College of Education in May 1998.

It was during the evening when some few girls were laughing and crying uncontrollably at their hostels. Their behaviour was so strange that, it came to the notice of their schoolmates who reported the matter to the hostel staff. After a few days the bad spirits had taken an even firmer grip on the college of education, with more girls and boys behaving in an abnormal way. What was claimed to be 'Satanism' seemed to be passing from one student to another and from one class to another until whole classrooms and dormitories were haunted. The whole college was out of control as the situation got worse. It looked more like

a battle ground than the college premises. Hundreds of students at Adams College of Education were suffering these strange symptoms the whole week. What exactly caused the strange behaviour was unknown. Opinions differed with some blaming it on some form of spirit possession, and others on demons, Satanism; et cetera. Most people thought the outbreak was caused by Satanism.

The Christian students and educators tried to drive out the bad spirits at first, but when that did not work the school authorities took a decision to call in outside assistance. The minister arrived to drive out the bad spirits by performing exorcism. He prayed over the students who were affected and exorcised haunted hostels. He exorcised each student individually, and laid his hands on him or her and in the name of Jesus Christ called on the evil spirits to leave. After the exorcism the exhausted students were carried back to their dormitories to rest. Things got back to normal at Adams College of Education after a week. After the minister had done his work the school reopened and students had not felt the spirit's presence since. This is not the first time strange happenings in Adams College of Education. There are a number of educational institutions in which this mass hysteria has occurred, namely; Vukuzakhe High School at Umlazi in 1994, Moretele Primary School in Mamelodi in 1995, St John College of Education in Umtata in 1999 and Kalahari Primary School in 1992; to mention a few examples. The ministers who are usually the prophets and faith-healers from

the various African Independent Churches were called upon to calm down the situation from the afore-mentioned education institutions.

2.9 THE RESEARCH STUDIES WHICH HAVE BEEN CONDUCTED ABOUT TRADITIONAL HEALING AND FAITH-HEALING

The sorcerers who are the cause of the afflicted illnesses, and the various traditional healers who claim to be able to cure these supernatural causation: animistic, magical, and mystical theories classified by Murdock, Wilson and Frederick as quoted by Edwards et al; (1983:214) have been the major source of motivation in the research studies which have been conducted about the indigenous healing and the faith-healer who has established the National Christian Assembly of God Church.

2.9.1 INDIGENOUS HEALING

This section introduces indigenous healing practices of traditional doctors and shows how the traditional healing process is carried out, and to discuss the actual examination and healing of the patients who are suffering from the supernatural cause of illnesses. It is of paramount importance to discuss indigenous healing, since the traditional healing activities have been effected by traditional practitioners in the history of traditional medicine; and traditional doctors and prophets

practice indigenous healing within their communities to treat 'people's diseases' *ukufa kwabantu*, hence use can be made of traditional medicine in the education support services.

In order to find out through interviews and observations about indigenous healing, ten reputable traditional doctors 'izinyanga' were visited in the Durban areas; centres of traditional healing business at Berea Station, Ezimbuzini Bus and Tax Rank at Umlazi, Umlazi Township, and Folweni Township in the Province of KwaZulu Natal.

A two quire exercise book was used to record pertinent details. The researcher paid a visit to ten different traditional practitioners for three weeks, discussing, observing and recording all the relevant information pertaining to traditional healing. The first five subjects were told in the first interviews with individuals that they would be:

- asked to explain how they carry out the traditional healing process,
  - the actual examining 'ukuhlola' and
  - the divining tools that are used.
- asked to explain the treatment they give to the patients.

The questioning of the subjects with regards to the traditional healing process was carried out individually.

Then the researcher established rapport with the next five group of traditional doctors with each individual, before he observed the actual diagnosis and the healing process. The subjects were told as individuals that they would be:

- asked to actually practice the healing process in the presence of the researcher, that is;
  - actually examine the patient, and
  - treat the patient.

The patients and those who accompanied them to see the traditional healers were not aware that the researcher was an observer, only the subjects knew. They thought the researcher was a trainee 'udibi'. This was a secret between the researcher and the subjects so that the patients and their relatives could feel comfortable. The researcher made follow-up visits after to three patients who were receiving the treatment from the traditional doctors, in order to find how they were recovering one month later.

All traditional doctors emphasized the traditional diagnostic methods in their healing procedure. They also made use of similar traditional treatment methods. Discussions about and observations of traditional healing process, indicate that the traditional practitioners must first invite the healing ancestral spirits to be present and assist them in treating their patients. The ancestral spirits possessed by the

traditional doctors manifest their presence through actions such as grunts, snorts and hissing sounds.

The traditional doctors are able to examine the patients using the divining tools such as; the divining bones or shells, the divining mirror, the divining medicine in a small bottle. Some of them divine by ventriloquism *'ukubhula ngabalozi'* and others divine "by head" through the guiding ancestral shades. The narrative method, and the question and answer method are used by the traditional practitioners and the patients or the people who are accompanying the seriously ill-patients. The traditional doctors use their divining tools while asking the patients various questions pertaining to their illnesses. They base their diagnosis on the information revealed by the divining tools and ancestral spirits, and on the information gleaned from the answers of the patients.

The divining tools and the healing ancestral spirits are able to reveal that the patients are suffering from the African diseases *'ukufa kwabantu'*. The traditional *'ukufa kwabantu'* theories a detailed discussion by Conco (1972), Berglund (1976), Ngubane (1977), Edwards (1985) and Gumede (1990) as quoted by Edwards (5,6) can be subsumed within the supernatural division as follows:

Animistic theories ascribe the disorder to the behaviour of some personalized supernatural agent, such as a spirit or God: for example, *abaphansi basifulathele* -

withdrawal of protection of the ancestral shades, mostly caused by disharmony within the home; *ukulahla amasiko* - failure to perform necessary rituals, such as sacrifices to the ancestral shades; *ukudlula* - failure to indulge in abstinence behaviour during a period of mourning believed to result in a form of compulsion neurosis; *ukuthwasa* - a "creative illness" following the calling by the ancestral shades to become a diviner, a religious conversion experience, *izizwe* - aggressive spirit possession occurring by chance; *indiki* - another form of spirit possession occurring by chance.

Magical theories attribute the disorder to the covert action of a malicious human being who employs magical means to injure his victim: for example, *ufufunyane* - spirit possession attributed to sorcery, *idliso* - poisoning attributed to sorcery, *iqondo* - genito-urinary disorders attributed to sorcery; *umeqo* – disorder attributed to stepping over a harmful concoction of a sorcerer; *umhayizo* – crying attacks attributed to sorcery by love potions; *uvalo* - anxiety attributed to sorcery aimed at lowering the defenses; *ibulawo* - bodily pains attributed to sorcery; *tokoloshe possession* - witchcraft through a familiar, the supernatural agent of a witch.

Mystical theories explain disorders in terms of an automatic consequence to some act or experience of the afflicted person: for example, *umnyama* – experiencing illness or adversity because of contact with places or people immediately

associated with the major life events, such as birth, death, and menstruation; *umkhondo omubi* - a dangerous track, or ecological health hazard such as lightning.

The traditional practitioners together with the faith-healers are able to treat these animistic, magical and mystical theories, whereas the western doctors cannot treat them, since they are beyond their level of understanding.

When the ancestral spirits of the patients are diagnosed to be the sole cause of illness, the traditional doctors may suggest and emphasize the importance of cleansing the patients' ancestral spirits in order to restore their protective function. The following obligations are complied with, namely; the ancestral spirits in the graves are brought to the patients' homesteads if need be; an animal, that is; a goat or beast is actually slaughtered with the customary beer libation, as a sign of loyalty and remembrance. The whole patient's homesteads are sprinkled with fluid medicine (*intelezi*).

If the diagnoses reveal that the patients have been be witched, they may request themselves to be cured by the traditional doctors. The traditional practitioners start the treatment by giving the patients various types of herbal medicine. The indigenous doctors' procedures for treatment may incorporate the patients and their social groups as a whole into the treatment programmes.

2.9.2 THE NATIONAL CHRISTIAN ASSEMBLY OF GOD CHURCH

The researcher introduces the founder of one of Africa's most powerful independent churches - the National Christian Assembly of God Church. This section of the research is stimulating for its empirical data about the present new church involvement in traditional health systems and community development. The research extended over a period of about three weeks. The research took the form of observations and interviews.

2.9.2.1 THE EARLY LIFE OF THE FOUNDER - REVEREND SANDILE CHRISTOPHER NDLOVU

Rev. Sandile Christopher Ndlovu was born and bred in Portshepstone in a rural place called Ezingolweni in the Province of KwaZulu Natal on the 10th April 1965. Sandile is the seventh of eight children born of Christian parents, Albertina (69) and her husband Isaac Ndlovu who passed away in 1997. His sisters and brothers are; Makhosazana, Elizabeth, Nkosinathi, Hilda, Amos, Jackson and Patrick, who is the youngest brother. The whole family were members of the African Gospel Church before they joined the National Christian Assembly of God Church.

Sandile was educated first at Emthini Lower Primary School, and then at Eqhinqa Higher Primary School. He attended matric (Grade 11 and 12) at the well-known Egcilima High School in the same district. As a family of eight children, they were not born with a silver spoon in their mouths. They were entirely dependent on their sole breadwinner, their dear father. Sandile wanted to continue with his studies and to study medicine - a wish shared by his parents, brothers and sisters. But at the back of his mind there was always another worry - the higher he progressed in school, the more money his parents would have to pay for fees. Sandile was not only matured enough to realize this, but also matured enough to find a solution.

When Sandile was doing matric, he looked for employment at Ramsgate, where he used to work on Friday afternoons, Saturdays and Sundays. He was most aware that he had to help his parents financially in order to achieve his goal. Sandile learned and worked with a serious sense of purpose. Sandile's employer was visited by his friend, who was a White man from Johannesburg. He asked Sandile what career he intended to follow. Sandile told him that he wanted to be a medical doctor. He gave Sandile three cheques with a sum of nine thousand rands, so that Sandile could support his parents and pay for his education. Sandile was most grateful to him for his kindness. He went home and gave the cheques to his parents.

Jackson was sent by his parents to the bank to cash the first cheque. When Sandile cashed the second cheque, he was unfortunately arrested. Sandile and his brother, Jackson were both taken into custody by the police for three months; that is, January, February and March 1996. They were visited by their parents, Isaac and Albertina in jail, and their mother told them not to reveal the third cheque to the Police officials, to keep the third cheque a secret so that the White man who gave Sandile would reveal it. The court kept on postponing the case on many occasions, and in the end they were not found guilty and released. Rev. Sandile Christopher Ndlovu is married to Xoliswa Ndlovu, and they are blessed with two children: Nonkanyiso and Menzi.

2.9.2.2 THE FOUNDERS' CALL TO MINISTRY

The manner in which the National Christian Assembly of God Church was started is beyond the human's mind understanding. It sounds strange to some people when Albertina Ndlovu explains. She enjoys to report all events which occurred respectively before the church was established.

When Sandile was still a baby, his grandmother, Rose Lubanyana visited his parents. After a morning prayer, Rose revealed that she had had a dream in which she was told that the light of the lamp was going to shine in the family - meaning the Word of God was going to take place within the family. The family was surprised

and it was difficult for the members of the family to air their view, because this was not debatable.

Sandile was brought up like any other child within the family. What was really exceptional about him was that Sandile used to hide away when he met a person who had used traditional medicine as he grew up. Since then, Sandile has been against traditional medicine. Albertine, who is his mother, says if she hadn't witnessed this herself, she wouldn't have believed it.

When Sandile was in standard five (Grade 7), he used to suffer from a severe headache. Sandile would felt as if his forehead was tearing apart. His experience of pain occasioned the family a lot of trouble, but Albertina did not despair, she kept on praying for his child.

After the first week of April 1986, Sandile asked the whole family to pray for him because he had a strange dream. Sandile saw a White man standing with an old African man in a church building. He said that the White man instructed him to pray for water. Albertina asked his son how he could pray for water having not been converted. Sandile replied that he did not know. Sandile emphasized that the White man gave him the instruction to pray for water, so that he could fetch the youth from the wilderness. His mother asked him that; what was the youth doing in the wilderness. He couldn't answer.

One day, Sandile woke up his mother at dawn at about four o'clock, and told her that the White man came in a dream to tell him to start praying for water. He was told that a person would bring his or her water and Sandile would pray for water. Thereafter, a person would be able to explain what the Holy Water had done for him or her after he or she had used it. Sandile's new life started when he prayed for water. The feedback Sandile got from the people was positive - people spoke highly of him and they believed Sandile had received the healing Power from God. Unfortunately, the authorities of the African Gospel Church condemned the use of water. Sandile told his parents to become members of the Faith Mission Church. Sandile left the African Gospel Church and he did not join any denomination.

One day the same White man came in his dream, and he told Sandile to wait for the name of the church he should establish. After a few days Sandile revealed that when he was in a deep sleep he heard a 'voice' speaking to him. The voice said: "The name of the church is - the National Christian Assembly of God". According to Albertine, his son, eventually formed this church in 1986, after the aforementioned events had occurred respectively. Sandile had received a calling through revelation in dreams to proclaim the Word of God through prayer and miraculous healing. Albertina herself acknowledges the child's calling - a view shared by the whole family and relatives. Perhaps the important decisions

have already been made from birth and now he has to fulfill the commands of God.

2.9.2.3 THE DEVELOPMENT OF THE NATIONAL CHRISTIAN ASSEMBLY OF GOD CHURCH

Rev. Sandile Christopher Ndlovu, the founder, - referred to by his congregation and people as 'uBaba uBhishobhi' Father Bishop, 'uBaba uProfesa', Father Professor, and 'Umthandazi uNdlovu' Prayer healer Ndlovu, started praying and sharing his experience with other sick people, and they were healed. The first main branch referred to as the Faith Healing Centre, was opened up 1986. It is situated at Ezingolweni about 40 kilometres South of Portshepstone and is like a self-contained village made up of the central church, which houses approximately 1000 people. There is a restaurant, administration offices, four roundhouses, four flat houses, ten caravans and two hundred houses for the patients and people who seek help.

As the church gets bigger and bigger, it has formed several branches around the country. It has now twenty four branches. The hierarchy of the National Christian Assembly of God Church consists of the Archbishop (the founder), Bishop, Deacons, Priests, Evangelists and Sisters. They decided to dedicate their life to the worship of God, and they work in a coordinated manner in order to

spread the Word of God and to serve the people - heal them and resolve their problems.

(1) Faith Healing Centre

The Faith Healing Centre is different from other branches because of the various activities which take place in this centre. This venue is particulary popular for worshipping services and healing practices, programmes for Bible lessons and community development projects. The daily running of the Faith Healing Centre is charity based, entirely dependent on public donations and contributions. The church members in other branches only meet every Sunday for worshipping services.

(a) Worshipping and faith-healing practices

The National Christian Assembly of God Church healing activities start at dawn with spiritual healing in the church service. The congregation sing choruses and clap hands with increasing intensity. The priest read some few verses from the Holy Bible and preaches. The spiritual healing service ends by prayer; that is each and every individual prays loudly.

The physical healing service begins at 7h00. During this service spiritual healing and physical healing are always seen as one ritual event which provides a framework for healing occasioned by illness, protective healing and preventative healing. The people who seek a cure for everything from ill-health to employment problems, or to ask to get lucky enough to win a large jackpot, enter into a house in silence carrying plastic containers full of water. The worshippers bring Salt, Candles, Sunlight Soap, Lux Soap, Vaseline Blue Seal, Needles and Nails to the table so that these items can be blessed. There is an opportunity for confession 'ukuhlambuluka' for some individuals who have committed wrong deeds. The priest who has the power and gift to identify those who resist, instructs them to move out for confession. They are at liberty to join the congregation after confession.

During the healing service the worshippers sing, clap hands and pray with a strong feeling of the presence of the Spirit of God. A few Biblical texts are read and the priest seldom refers to healing wonders of faith in his sermons. There is a session of the public testimonies of faith-healing by people who have been cured. The people claiming they have been healed by Holy Water, testify its amazing healing powers. Some say they have been saved from alcoholism, ill-health or bad luck. The Archbishop's secret is precisely in God's Healing Power. He is able to identify people by their names and surnames who have serious problems. They are all sent to his office for his immediate attention. If need be, a list is compiled

for people with serious problems to meet the Archbishop the next day. They sit quietly approximately two hours in the Archbishop's office, facing a television set. The Archbishop operates the TV Set and he informs people as individuals as their problems appear on the television screen. The people are unable to see for themselves their problems on the screen. Thereafter, all these people are given a special treatment which include curative healing, protective healing and preventative healing.

The healing service ends up with the blessing of water, leaving people with high emotions. They believe the blessed water has healing powers. Hence, it is a source of strength. When you believe in something, you have hope, when you have hope the burden is eased. There is no mistaking that there is something very special about blessed water. The holy water will continue to heal people because all will tell you its worth.

The Faith Healing Centre holds daily healing services at two different times: morning and noon on Mondays, Tuesday, Wednesdays, Fridays, and Saturdays. The congregation also attend worship services daily at dawn and in the evening. The main church service takes place every Sunday.

The researcher met a number of people who were previously healed and those who came for the first time to ask for help. Themba Ngema (57 years) from

Umlazi Township, KwaZulu Natal Province, said that he had become terribly sick in 1990 while he was employed in Johannesburg. He was afflicted by his ancestral shades 'abaphansi' which demanded him to become a traditional diviner. This was against his will as he had no desire of becoming a diviner. Themba was taken to different herbalists and diviners, but they couldn't help him. Themba met a man who was very concerned about his health, and he insisted Themba must go to the Faith Healing Centre, as they would help him. Ever since Themba attended the center, he has been healed. Themba does not know how to explain this, he believes the faith-healer, Rev. S.C. Ndlovu cured him through the Power of God. Themba is now a full member of the National Christian Assembly of God Church.

Mesuli Qasana from Umtata, Eastern Cape Province, got sick at the beginning of June 1999. He couldn't move his neck because it was painful. Mesuli's right leg was also affected, and he could not stand without crutches. He was taken to Gatshane Hospital for treatment and he could not be healed. Mesuli was accompanied by his father Thembisile Qasana to see the prayer healer, Rev. S.C. Ndlovu. Thembisile claimed that his son was attacked by 'impundulu' the lightning bird.

(b) Saint Christopher College of Theology

The National Christian Assembly of God has its own college of theology known as the Saint Christopher College of Theology. The primary aim of this college is to empower a body of priests with a vast knowledge of the Holy Bible, and to train them for various special religious duties and for helping other people. The Bible lessons are offered once a month in the Saint Christopher college of Theology. The National Christian Assembly of God Church priesthood gets different chances of searching the Scriptures diligently in order to discover the basic truth of the Holy Bible. They acquire various skills of conducting sermons and more emphasis is put on preaching, praising and worshipping God. The church officials have developed a deep-seated faith and a healthy relationship with God through the Bible lessons that are offered in this college of theology. Hence, they are able to teach the church adherents the Bible teachings in their respective branches.

Due to its emphases on praising kind of worship, the National Christian Assembly of God church attracts many young people, and has given birth to a gospel group that is making a name for itself in the Portshepstone gospel scene. The group members believe that singing gospel music is their way of serving the Lord. They have developed spiritually and have faith in God through the gospel music.

(c) Sandile Community Development Project 2001

The Archbishop of the National Christian Assembly of God Church believes that the church is a part and parcel of the community, since the adherents of the church are the members of the community who experience various difficulties in their environment such as poverty, ill-health, illiteracy, retrenchment, unemployment; to mention a few examples. He has come up with the idea of forming the Sandile Community Development Project 2001 in order to save the community from its awful plight. His primary aim is to improve the quality of life for community members through job creation, community development, community upliftment and education.

The Sandile Community Development Project 2001 includes a vegetable garden, candle - making, poultry farming and a crèche. The garden supplies the community with fresh vegetables which helps to give them the nutrition they need. The people are taught the importance of agriculture and are trained to teach others within the community about the importance of nutrition. The candle - making division trains people to acquire special skills of producing candles. The community will soon depend on poultry farming for the supply of eggs and meat since poultry is now cheaper. The crèche division aims to build a strong foundation for the community children's future. A Medical Clinic is in the

pipeline's. The clinic will attend minor ailments, see to children's health, antenatal care and treat chronic hypertension and asthma patients; et cetera.

The Sandile Community Development Project 2001's ultimate goal is to make the whole community self-sufficient. This project has made tremendous progress with the assistance of the people who are committed to hard work. The founder believes that the community is going to benefit from the project and their lives will also be changed, since this is a community scheme which is meant to help everyone.

Rev. S.C. Ndlovu has become popular because of his healing abilities, and he doesn't expect financial gain. Through his healing success he has achieved a special reputation for being effective in curing illnesses which the medical profession has failed to cure.

2.10 **CONCLUSION**

The reality of traditional medicine has proved that the African people, through most of their history, have been conscious of the existence of traditional medicine and have owed even this consciousness to contrast between the traditional medicine of their own society and scientific medicine of some other with which they happened to be brought into contact. The ability to understand the traditional

medicine of one's own society, as a whole, to evaluate its patterns and appreciate their implication calls for a degree of objectivity which is rarely, if ever, achieved. It is no accident that the modern scientist's understanding, of medicine has been derived so largely from the study of African Egyptians traditional medicine where observation could be aided by contrast. Those who know no medicine and the art of healing other than their own cannot know their own cultural beliefs.

The fact that some of the problems encountered by pupils in school situations of the present day need cultural solutions which include pupil's beliefs, and their patterns of behaviour, calls for the provision for traditional medicine in education, in order to eradicate problems pertaining to supernatural causes of illnesses. It is, therefore, quite important for school authorities, communities and traditional curers to work hand in hand for the benefit of the schools and the community as a whole. Traditional healers will be responsible for solving supernatural problems where these extend beyond the problem-solving abilities of established schools and their authorities. There is no doubt from the preceding discourse that any educational effort which underestimates the involvement of traditional healers is an abortive endeavour, since they are the only people who can treat and cure the pupils who are suffering from illnesses of a supernatural nature.

CHAPTER THREE

3.0 TRADITIONAL MEDICINE IN A CHANGING SOCIETY

3.1 INTRODUCTION

African traditional healing practices are based on beliefs which existed long before the development and spread of modern scientific medicine. These practices vary widely between different African countries, in keeping with their social and cultural heritage and traditions (Karim et al; 1994:4). According to traditional beliefs, a person does not choose to become a traditional practitioner. It is not a choice, but a call by ancestors that occurs from generation to generation.

The contact between the Zulu people, with their traditional way of living, and the White with a Western way of living caused rapid social changes to take place, hence the Zulu people's indigenous way of living has been interfered with (Dreyer, 1980:42). Acculturation has almost occurred among various groups of different races. According to Van den Aardweg and Van den Aardweg (1988:8) acculturation is a process whereby a continuous flow of traits, behaviours and ways of life pass between peoples of different cultures, resulting in new life styles. It is the change which takes place in the lives of people when they are exposed,

over a period of time, to the influence of another, more dominant group. The African people are exposed to the new life styles which is strictly acculturation of the Western set of habits, attitudes and behavioural codes.

Immigrations from Western European and American countries brought with them the customs, institutions and beliefs of Western culture. Consequently, African people became westernized, and this resulted in urbanization, industrialization and christianization. Dreyer and Duminy (1983:184) maintain that during the transitional period industrialization, christianization, Westernization and urbanization brought about enormous changes in the family lives of Black people. Through diverse changes in society, the African people with their traditional medicine have been greatly affected in many various ways.

In this chapter, attention will focus on the influence that changes in society had on the traditional curers regarding their traditional medicine. A review of the role of traditional medicine with regard to the provision of primary health care will be examined. The barriers to learning and development will be discussed. The nature of support services to be provided in all educational institutions in order to overcome the aforementioned barriers will also be discussed.

3.2 TRADITIONAL MEDICINE AND SOCIETAL CHANGES

Originally traditional medicine was practiced solely or exclusively by Black healers who are an integral part of all African cultures and communities and have been since time immemorial, and fulfil functions which go far beyond those which biomedically trained health-care workers (for example; medical practitioners, nurses, community health assistants) see as appropriate to their professions. The traditional healers have enormous influence with the patients and their families and communities and, in general, make positive and beneficial contributions to the cultural and spiritual lives of the individuals and the communities. They share with the patients a view of the world and the way it works which is completely alien to the non-African Western-orientated health-care workers. In particular, the view which the patients share with the traditional healers with regard to the nature and causation of disease is totally different from that held by the biomedical workers, and this makes it difficult, if not impossible, for Western doctors or nurses to understand all those aspects of the patients which are essential to really effective medical care. According to Nyathikazi (1999:8) during the early days of the missionaries, traditional healers were referred to as 'quacks' simply because Western culture did not favour or understand traditional means of healing.

It is not uncommon these days to see droves of White, Coloured and Indian healers joining the race to the metaphysical world of the African traditional healer.

One often finds White, Coloured and Indian healers in the busy streets in cities and towns buying plants and other animal portions. They practice traditional medicine in their communities and in the Black communities. This proves that in these days skin colour or race is not important in choosing what profession we follow in life.

The growing number of White, Coloured and Indian healers in South Africa has raised a concern in the Black community, especially, the traditionalists, who have always held that traditional healing and the belief in ancestors are theirs by birthright. The researcher visited some African traditional healers to find out why the authenticity of White, Coloured and Indian healers is being questioned and if they do have anything to contribute to the primary health care of the people.

Some traditionalists feel that Whites, Coloureds and Indians should not be allowed to 'abuse' African healing practice because they were not brought up like Black people and "do not have ancestors". Some traditional practitioners who oppose Whites, Coloureds and Indians practicing as traditional healers are Dr Sosobala Mbatha, a famous traditional healer in KwaZulu Natal Province; Jericho Mhlongo, the chairman of izinyanga National association of South Africa; Mhlahlo Mlotshwa, the immediate past chairman of Izinyanga Association of

KwaZulu Natal Province; and Raymond Mhlaba, the chairman of Izinyanga of KwaZulu Natal Province. They all unilaterally say that:

> People must bear in mind and understand that not every Tom, Dick and Harry can just become a traditional healer. It is not a choice, but a call that occurs from generation to generation. The Whites, Coloureds and Indians who claim that they practice traditional healing are misleading our Black communities and the whole nation. They are resorting to traditional medicine practices in order to turn our respectful traditional practice into business. They are only interested in money and sooner or later they will cease to exist.

The researcher also visited some White, Coloured and Indian healers to find out whether they were able to work through ancestors as Black traditional healers do. They feel that the traditionalists and some of the Black people should change their attitude and think beyond racial boundaries, in order to understand that race or colour is not a barrier to become a healer using traditional "umuthi" medicine. Shirley Celliers, a well-known White diviner of Amanzimtoti; C.V. Pillay, herbalist and a traditional healer, who is doing famously in his work of healing people and solving their problems; Dr Mohamed P.K., an astrologer and a healer who has the knack in using traditional medicine, his place is always packed with desperate people who seek his help; and Dr Kassim, the most active herbalist and

healer of Isipingo, who has made a new dimension in healing. They all assert that:

> It's high time that people, in particular our colleagues (Black traditional healers), understood that we do have ancestors whom we call spirits, and we are healers by calling and not by choice. We possess the healing power through communication with our spirits and we heal illnesses or solve problems of the people. We have undergone all the traditional healing initiations as diviners, healers, and prophets under the guidance of African traditional healers. We have also assisted a number of various races (Blacks, Indians, Coloureds and Whites) to become traditional curers over the years. Therefore, it is our responsibility as healers, diviners, counselors and prophets to help all people.

From the fore-going it may be noted that all the races do believe in spirits or ancestors. As a result Indian, Coloured and White healers are similar to Black traditional healers. The former healers may not interact in the same manner the latter traditional healers do with their ancestors, but they do have spirits or ancestors and the power of healing. They are exposed to traditional healing through living and working with Africans, hence the healing experience which Indian, Coloured and White healers acquire from the traditionalists is alien to

Western culture. However, engaging in African traditional healing does not make Indians, Coloureds and Whites ignore their own culture completely.

3.3 TRADITIONAL MEDICINE AND INDUSTRIALIZATION

The industrial Revolution from 1750 to 1850 brought about a drastic change in the primary form of Black society. The traditional, rural, community life-style of Black people has become a more formal business like way of life (Le Roux (ed), 1992:83). Hence industrialization has brought about the participation of traditional healers in the labour force.

Most of the traditional healers left the countryside with a hope of finding jobs in the towns and cities. The cities and towns provide fewer jobs than the number of those seeking them. In their failure to find jobs in the formal sector they did not go back to the countryside, they remained in the towns and cities and got distributed to different informal activities including traditional healing. Some traditional healers are engaged full time in this activity of traditional healing, and some do it part time. The minority of traditional healers are presently employed in industries but they practice traditional healing in order to get more money to supplement their low wages. Those who are part time include those who are still looking for jobs, and those who are involved in the traditional healing activity in order to increase their income. The majority of traditional healers who are full

time in this activity of traditional healing have no other sources of income except for this activity.

The traditional healer's role in the community is highly influenced by the monetary economy of the industrial world nowadays than in the old African system. In the olden days a person would pay by giving a traditional healer livestock for his or her services. Today money is used in exchange for medicinal services. In the olden days the traditional practitioner would go out with his assistant or "Uhlaka" and collect the required herbs from the forest or the bush. In the cities and towns today, the selling of herbs and drugs have become one of the main economic activities.

3.4 TRADITIONAL MEDICINE AND URBANIZATION

Urbanization is a process which involves the migration of people from rural areas to urban areas and a continuous period spent there. People in urban areas are in the different phases of urbanization depending on the length of time they have been in towns or cities as well as their interests. The increase in numbers is a result of the natural increase that is rapid, but people do not have much land at their disposal to which they can spread. Mayer (1962:580) defines urbanization strictly in terms of relationships: a person is fully urbanized when his extra – town ties - that is, with people in the rural tribal areas - are of minimal importance or

have completely disappeared in comparison with his social relationships in the town itself.

Urbanization is a direct result of industrialization. Cities are attractive for many people from rural areas. People are not only attracted by the possibility of a better life provided by the cities, but they are also pushed out of the rural surroundings by factors such as machinization of agriculture. They flock to towns and cities to seek employment at the numerous factories and industries. All these unfortunate migrants need to meet their basic needs of food, shelter and clothing and therefore resort to informal ways of living such as squatting and surviving on informal employment. Traditional healing is one such activity.

The informal sector is one of the main alternatives used by the urban unemployed in most of the towns and cities. It provides the answer to the urban unemployment problem, because the cities are failing to provide jobs for all these unemployed people. This is what happens in towns and cities as people are not all permanently employed, but are waiting for the time when they will be employed. Hence, people decide on alternative means of making a living by resorting to traditional medicine practice activities. Moser (1984:42) points out that informal employment functions as a refuge from poverty and an alternative to destitution for those deprived of access to formal employment.

The main reason for engaging in traditional healing activities is the lack of jobs. The majority of traditional healers in towns and cities were once involved in wage earning, and others joined traditional healing activity because of unemployment. Those who were once engaged in wage earning, lost their jobs and resorted to traditional healing activity, using the knowledge that they collected from their environments of origin. This agrees with what Bryant (1966:27) observed among the Zulus that the medical profession is hereditary, one of the medicine-man's sons is compulsorily introduced by him to the trade as his assistant during his life and inheriting his legacy of bags and bundles of medicine after his death.

3.5 THE ROLE OF CULTURE IN PRIMARY HEALTH CARE

The importance of traditional curers in primary health care services cannot be overemphasized. The majority of countries which have adopted primary health care have not incorporated traditional practitioners into primary health care services, although this can be of mutual benefit. According to Karim et al., (1994:12) African researchers are taking a closer look at African traditional healing with a view to collaboration between traditional healing and biomedicine which will lead to the appropriate utilization of various health resources. A good example can be found in China, one of the few countries that has fully integrated traditional medicine (ocupuncture and herbalism) with biomedicine. This has resulted in tremendous progress in the control of infectious diseases, eradication

of some childhood ailments and better distribution of material and child health services.

In many African countries, collaborative initiatives at national level have been started, with Ministries of Health having the responsibility in most countries. In nineteen countries traditional medicine has been introduced into syllabi of specialist institutes or university departments, as research by Karim et al., (1994:12) clearly shows. This will create a culture of public health in existing centres involved in health care for the integrated training and exposure to the core values which public health medicines and clinical medicine share for the benefit of all who care for the public's health.

The first contact between the rural Black patients and health care services usually occurs in the traditional healing system. The traditional curers and their patients have the same culture, live in the same community and speak the same language, hence the traditional doctors are acceptable and accessible. The traditional healers know about the disease pattern of that community. If well trained, they can identify diseases that can be prevented or modified, and they are sometimes able to cure some diseases. Hence, traditional practitioners fulfil Morell's four primary health care objectives (Mellish, 1984), namely; that primary health care:

3.5.1 should be acceptable to the people;

3.5.2 should be accessible to the people;

3.5.3 should identify those medical needs of the population which can be prevented, modified and treated; and

3.5.4 should make maximum use of the available manpower and resources to meet the medical needs of the people.

3.6 TRADITIONAL MEDICINE AND TRIBAL CUSTOMS

Traditional life is the root of African life, and holds the key to the soul of the African people. Traditional beliefs and traditional medicine are part and parcel of the African culture. Different cultural practices among ethnic groups do exist. Certain rituals are performed by which girls and boys are formally introduced into adult world. Traditional healers are essential to the success of the generally recognised ceremonies to provide primary health care service, since they are in most cases the first and nearest contact with tribal communities.

The remarkable cultural custom which is practiced by the Xhosa speaking people in their tribal areas in the Eastern Cape Province is traditional circumcision. This is also practiced by the Shangana and Tonga collectively known as Tsonga in Mozambique, and there is no cultural difference left. The boys "abakhwetha" including those who are school attendants leave their home and stay in the mountain to be circumcised. They are not circumcised in hospital because it is

more traditional for them to attend a circumcision camp in the bush for a period of two or three weeks and graduate with other initiates, including old men. The Xhosa and Tsonga people believe that they must undergo this practice in order to uphold their culture so that when they die they do not fear the anger and rejection of their ancestors.

The removal of the foreskins at the end of the sex organs of the "abakhwetha" is traditionally done by the respected mentors. They are not given anaesthetic but some brown medicine which is prepared by traditional practitioners is applied in order to heal up the wounds quickly. The boys "abakhwetha" are usually exposed to extreme situations, such as; unfavourable weather conditions, bleeding, dehydration; to mention a few examples. It is believed that those who are able to withstand these critical conditions will grow up to be strong and brave men. They return to their homes as respected adults, with the discipline and spirits of the ancestors already in them and they can differentiate between wrong and right, and they must be reasoned with as adults. When they get back to their families, men, women and children from the community welcome the new men clapping and stamping in a special ceremony.

Sometimes two or three boys "abakhwetha" get seriously ill in the circumcision camp and become restless because of bleeding and dehydration, and they are admitted to hospital and receive medical treatment. The scientific doctors are able

to save their lives and those patients whose lives have worsened quickly lie quite still, give feeble gasps and soon later die. Those who recover from this mist are discharged from the hospital.

The aforementioned tragic event which usually takes place yearly in the Eastern Province could be solved by the traditional healers and modern doctors working hand in hand with an aim of providing primary health care services within the tribal communities. If they were to work together, many patients would be saved from complications of certain ailments. Gradually, maybe, the traditional healers with scientific doctors will come to know and to understand one another, and slowly mutual confidence will be established. Confidence in both traditional healers and modern practitioners will eventually produce confidence in both traditional medicine and Western medicine. Hence the scientific practitioners will take over where the traditional doctors have failed to help the patients, and vice versa. Consequently, an understanding of the African belief is necessary by the scientific doctors, for the solution of the problems which trouble the African people today. None of the modern practitioners indeed have developed this knowledge.

Since the African and European ways of life are so different, both traditional and modern doctors should collaborate in the treatment, in particular, of Black patients. The scientific doctor or the traditional healer who does not consider collaboration will do patchwork only, especially, if the Black patient needs the help of the traditional

practitioner or vice versa. The Black patient will suffer the consequences in the long run. But in the meantime both the tribal and the urbanized Black Africans will continue to consult the traditional doctors, and seek their help for the social, economic, political and medical problems which trouble them, for only traditional healers, are the representatives of African beliefs in which all African people are still spiritually rooted. Only they understand the African beliefs fully.

3.7 THE ROLE OF TRADITIONAL MEDICINE IN PRIMARY HEALTH CARE

The concept of primary health care has been described by the director – general of the World Health Organisation in his report to the 28th World Health Assembly in May, 1975 as follows:

> "Primary health care consists of simple and effective measures, in terms of cost, technique and organization which are easily accessible to the people requiring relief from pain and suffering and which improve the living conditions of individuals, families and communities. These measures include preventive, promotive, curative, rehabilitative and community development activities. These measures are aimed at providing answers to the fundamental human health needs, which are expressed as:

1. Where can I go and what can I do for the relief of pain and suffering?
2. What can I do to live a healthy life?".

(Mellish 1984:213)

Primary health care is about the major health problems in the community at large. Community health care practice requires co-operation between traditional healers and health care professional, such as doctors, nurses and social workers as well as professionals concerned with social, economic, educational and political matters. The traditional curers who are the most important primary health care service providers in black communities, the health care professionals who provide health care services to the people, the socio-economic conditions which make it possible for people to live in conditions conducive to health, as well as, the adequate provision of educational facilities to educate all people to a level where they can earn reasonable living, and political responsibility on the part of the government party to ensure legislation aimed at promoting the health of the nation, are all part of the provision of primary health care.

The health of the people is a concern of all the citizens of the country. In order to ensure that health care is readily accessible and acceptable in the community, optimum self-reliance and community involvement for health deployment are necessary. The successful participation of community members enables communities

to deal with their health problems in the most appropriate ways and leaders within the community are in a good position to make rational decisions concerning primary health care and to make sure that suitable support for health and allied projects. The traditional healers are respected community leaders and members who can encourage community participation. Hence, primary health care workers should therefore encourage rapport between themselves and traditional practitioners and birth attendants.

According to Bannerman et al; (1983:318) developing countries pose a picture of want and deprivation with inadequate resources, a dearth of manpower and no definite hope of amelioration in the foreseeable future except through the adoption of unorthodox measures such as exploitation of useful traditional health practices. This includes a wider use of locally produced herbal medicines and an incorporation of traditional practitioners into the health team.

In the majority of developing countries the burden of disease, and death continues while resources for health remain very limited. In urban areas, which accommodate only few urbanites of the total urban population, health facilities are so excessively expensive that only rich people in the towns and cities can afford to pay for the specialist services using such expensive technology. Because so many millions of people have no access to these expensive health facilities, the research by Bannerman et al; (1983:319) clearly shows that a number of developing countries

in Africa, Asia and Latin America are exploring the possibilities of developing their well known and tested herbal medicines for use in primary health care centres. These medicinal plants are generally locally available and relatively cheap and there is every virtue in exploiting such local and traditional remedies when they have been tested and proven to be non-toxics, safe, inexpensive and culturally acceptable to the community.

In many of the developing countries primary health care devolves or passes on the various categories of traditional healers, namely; herbal vendors, homeopathic herbalists, traditional diviners, head diviners, bone throwers, whistling diviners, faith|prayer healers and prophets. They provide considerable health care services to many millions of disadvantaged people of the world's population who have no access to health care facilities. Some traditional curers have good liaison with each other rural community services. They have this communication so that the optimum use can be made of primary health care for the ultimate benefit of the disadvantaged groups whom they serve. Traditional medicine therefore has a vital role to play in primary health care in terms of numerous numbers of people served by that care system throughout the world and in spite of any defects. Traditional medicine is therefore the life blood of primary health care, since the rural communities depend largely on traditional healers as their health care service providers.

3.8 THE SERVICES OFFERED BY THE TRADITIONAL HEALERS

A variety of services are offered by the traditional practitioners. Some of the traditional doctors, namely; Dr Kassim, Dr Mohamed P.K., Dr C.J. Dube, Dr G.M. Ndlovu, Dr T.M. Mthimkhulu, Dr W. Dube, Dr J.B. Dlamini, and Dr Karonga who were visited by the researcher in Durban and surroundings, are able to heal, treat and solve long time sicknesses and problems, and offer some types of services using typical African and Arabic herbs. The traditional doctors' consultation fees vary according to the different types of diseases which range from simple to complicated diseases. Some of the diseases or problems the traditional healers can treat or solve are:

Headache; stomach ache; ring worm; pimples; venereal diseases, scab and sores; insanity; diabetes; asthma; sharp pains; high blood pressure; stroke; epilepsy; diarrhoea; bewitched people; one with bad luck; women with pregnancy problems; women who cannot produce; lack of strength in body; to be liked at work; prevent thieves from attacking homes, shops and cars; education (helping a child who suffers from "*ukufa kwabantu*" an African disease as a result he or she cannot pay attention to his or her school work); promotion; customer attraction; court cases; demand debts; removal of misunderstandings with anybody; to bring back a lost lover; misfortunes; pains in wombs and bladder; bringing back lost

properties; if you want stopping of divorce (husband or wife) with immediate effect; and many other diseases.

The traditional practitioners also offer the following mysterious services, namely;

Ukubhula - telling a patient the cause of ill-health and/or the agent that has caused the illness and suggest how it can be treated.

Ukuqina - strengthening or protecting the body against witchcraft and dangerous weapons such as firearms and knifes.

Ukumisa - protecting a female from miscarriage .

Umendo - increasing a woman's chances of getting married.

3.9 TREATMENT METHODS

There are several treatment methods used by traditional curers in the administration of herbal medications. Edwards et al., (1986:18-23) discuss the treatment strategies as follows:

Ukulungisa idlozi - the process of making peace with the ancestral spirits.

Ukuphalaza (emesis) - vomiting after the use of an emetic.

Ukuchatha (enema) - using of enemas for stomach complaints.

Ukubhema (intro-nasally) - inhalation of powdered medicine.

Ukushunqisela - inhalation of the smoke of powdered medicine.

Ukuncinda - sucking of hot liquid medicine from a hot container with fingertips.

Ukugquma (steaming) - the use of medicine vapour whereby the traditional healer covers the patient with a blanket or large skin over boiling medicine in a pot.

It is believed that as the patient sweats, the perspiration eliminates the cause of sickness.

Ukudla imithi (taking of medicines) - taking of medicine orally for treatment.

Ukugcaba (ethno-vaccination) - rubbing of medicine in a powder form into incisions for treatment.

Ukweqa udengezi - jumping over a large piece of clay hot container with the burning powdered medicine.

Ukubethela - strengthening or protecting the home against witchcraft whereby a special traditional doctor put underground certain medicines at four corners of the yard. *Ukubethela* also involves *ukugcaba* (ethno-vaccination) of the whole family.

Ukwethwasiswa - special training leading to becoming a traditional diviner.

In addition to the aforementioned treatment strategies, some of them are;

Ukuthunqisela - burning of incense which it is believed to appease the ancestors.

Ukuthoba - use of a warm cloth with liquid medicine on any part of the body such as aching feet or knees to lesson pain or swelling.

Ukukhunga - refers to the giving of a gift to a new-born baby. The cow or goat is slaughtered and the baby wears the skin around the right-hand wrist.

On the basis of the foregoing discourse; the role of traditional medicine in primary health care, the services which are offered by the traditional healers, and their treatments strategies; one can conclude that there is a dire need for the traditional healers to work hand in hand with other professionals, in order to eliminate the various barriers to learning which are encountered by learners in education.

3.10 THE BARRIERS TO LEARNING AND DEVELOPMENT

It is an indisputable fact that the various educational institutions prepare learners for what they can expect to be able to do, and for what other people expect of them to do in their communities throughout their lives. While the learners are learning, they may encounter various problems which may cause learning breakdown or exclusion. Therefore, if the education system is unable to provide for and accommodate a diversity of learners' needs and system needs, the learner or the system may be hindered from being able to engage in or sustain an ideal process of learning. The factors which make impossible for the system needs and learner needs, which cause the learning breakdown or which exclude learners from the system have been conceptualized by the National Commission on Special Needs in Education and Training (NCSNET), and National committee on Education Support Services (NCESS) as barriers to learning and development. These barriers can exist within the education system, within the educational institutions, among learners and within the broader social, economic and political context.

There are permanent barriers in the learner or the education system, and some may also arise during the process of learning. The barriers can be prevented from occurring by controlling and meeting a range of various needs among the learner population and within the education system at large, if effective learning and development is to be provided and sustained. A report of the National Commission of Special Needs in Education and Training (NCSNET), and National Committee on Education Support Services (NCESS) (1997:12) stipulates the key barriers to learning and development as: socio-economic barriers, lack of access to basic services, poverty and underdevelopment, factors which place learners at risk, attitudes, inflexible curriculum, language and communication, inaccessible and unsafe built environment, inappropriate and inadequate provision of support services, lack of enabling and protective legislation policy, lack of parental recognition and involvement, disability, lack of human resource development, and lack of access to traditional medicine. A lengthy discussions of the aforementioned barriers will be presented because; these are the key barriers that exist within the education system as a whole, which can hinder effective learning and development of learners if they are not prevented, minimized or removed, through the provision of education support services.

3.10.1 SOCIO - ECONOMIC BARRIERS

Socio-economic barriers refer to existing problems within the learners' environment that affect the learning process economically, causing effective teaching and learning breakdown or the exclusion of the learners from the education system. The influence of the socio-economic barriers on the learners tend to delimitate or fix the limits of extrinsic and intrinsic motivation, especially where there are inadequate numbers of learning centres and other facilities to meet the education needs of the society. Most of the inadequacies in provision are linked to other inequalities in the society such as urban and rural disparities, as well as inequalities arising from discrimination on grounds such as gender, race and disability.

3.10.2 LACK OF ACCESS TO BASIC SERVICES

The barriers to learning resulting from the lack of access by learners to basic services include a lack of transport facilities, roads that are not properly developed and maintained that make learning centres inaccessible. This has an impact on the learning process, as the majority of learners are severely affected by these barriers especially, in many poor communities, particularly in rural areas. Thus the handicapped learners who should be attending schools or who wish to attend adult education classes are totally excluded from the system of education because of the non-existent of special transportation services.

The lack of access to other basic services such as health services, social work and welfare services, the provision of special educational programmes, facilities, or materials means that the majority of learners, especially those with severe disabilities, are unable to receive the necessary intervention and stimulation which would otherwise enable them to participate effectively in the learning process. The lack of intervention programmes, namely; preventive intervention, remedial intervention and compensatory intervention in the education system means that these services remain largely inaccessible to handicapped learners.

3.10.3 POVERTY AND UNDERDEVELOPMENT

Most learning centres do not satisfy the expectations and are unsuccessful in coping with the problem of poor learners. This results in learning children being unable to cope with the demand made upon them at the learning centres. The most obvious reasons of poverty for the families are, unemployment, retrenchments and other economic inequalities, as a result they fail to provide the necessary basic needs such as proper shelter and food. The studies have shown that there exist a relationship between poverty and education. Birch and Gusson (1964:6) support the aforesaid statement by stating that;

> "Poverty produces educational failure, and since lack of education reduces opportunity for employment, it in turn contributes to the perpetuation of poverty. Poverty and ignorance are thus mutually reinforcing".

In most cases the learners living under these unfavourable conditions are subject to increased emotional stress which leads to stunting their intellectual growth. Additionally, under-nourishment leads to lack of concentration and a range of other symptoms which affect the ability of learners to engage effectively in the learning process.

The majority of communities that are adversely affected by poverty have insufficient educational facilities, large classes with high pupil-teacher ratios, insufficient trained teachers in various subjects and insufficient teaching and learning materials. Although the pupil-teacher ratio at present is 1:40 in the primary schools, and 1:35 in secondary schools, this is not the case in many schools since the process of rationalization and redeployment of teachers implemented in 1998 has not been completed. The learners from the larger families or from families where one or more of the breadwinners are unemployed, retrenched or poorly paid do not get enough financial support; consequently, the learners drop out from schools to work to supplement the family income. People with disabilities are usually those most easily excluded from the education system and from the labour market and are therefore the most poverty stricken in any population. This perpetuates the cycle of limited skills with fewer work opportunities, increased likelihood of unemployment or poor paid work and, thus, ongoing poverty and exclusion of learners from the education system. Evans (1970:307) contends that family size is said to affect the learning process of the child at home, because, it is assumed,

the larger the family, the less attention the mother can give to her individual children. In the Black community, it is common to find a family comprising six or more members. As a result many parents find it difficult to give their children necessary individual attention and financial support.

3.10.4 FACTORS WHICH PLACE LEARNERS AT RISK

Certain conditions may arise within the social, economic and political environment from which the learners live which have negative impact on the learners' social and emotional well-being, thus placing the learners at risk of learning breakdown. These factors impact directly on the learners or on his family or community, and tend to deliminate or fix the limits of extrinsic and intrinsic motivation. Hence, the learners' emotional and social well-being and development are threatened.

The learners who are physically, emotionally or sexually abused eventually drop out of the education system. These factors adversely affect the learners and their families causing family breakdown and producing anguish and stress in the victims. There are serious problems within families such as divorce, ill - treatment and juvenile pregnancy which force children to leave their homes and live on the streets or even commit suicide. The bad conditions arising from the society as a whole place learners at risk. The learners are exposed to many dangers of school unrest, faction fights, civil wars and other forms of political violence which

become the dominant factors in the leaning environment disruption and cause trauma to the victims. The high levels of mobility of families resulting from processes such as urbanisation, the establishment of informal settlements, eviction of farm workers and families being forced to seek refuge status in safer environments also lead to disruption of the learning process and, ultimately, to learning breakdown. This abnormal increase of the population in towns and cities create numerous social and educational problems.

It is evident that if the high levels of violence, escalating riots and criminal elements who operate freely in the turmoil created are common practice in the environment, the lives of educators and learners are at stake, hence proper teaching and learning are disrupted. Consequently, the lack of security in the learning environment becomes a barrier to learning and development. The lack of provision of basic amenities at learning centres such as electricity, water and toilets creates an unhealthy environment for educators and learners. Problems such as natural disaster or epidemics which arise in any society have a significant impact on learners. For example, when the houses in rural and urban areas are destroyed by floods after the storm, people who survive live under strenuous conditions. Many learners have not only had to be excluded from the education system, but have also had to deal with the loss of family properties and family members, particularly breadwinners.

In the light of the above discussion, it becomes clear that the impact of socio-economic barriers is the day to day burden for those learners who are already excluded from the education system. If such factors which place learners at stake continue unsolved, there is little hope for proper teaching and meaningful learning, hence learning breakdown. Bold steps in the education system are therefore urgently needed to curb these undesirable factors by meeting the learners' needs.

3.10.5 ATTITUDES

The negative attitude of parents towards their school experiences remain harmful barriers that are difficult to overcome or prevent since they are not recognisable as they impinge on the learner's performance negatively. These parents do not accept such responsibilities as: ensuring that the learner attends school regularly, and co-operates positively; providing favourable environment circumstances within the family that will promote educative teaching. Consequently, the learner functions at the level of attainment in the basic subjects will below his general educable capacity, and drop-out from school. Kuethe (1968:33) confirms the afore-said argument by proclaiming that in homes where the child hears education described as a waste of time, where teachers are regarded as busy bodies, and where the adults constantly talk about unpleasant aspects of their school experiences the child acquires an attitude that will give him an almost

insurmountable handicap at school. From the above exposition of the negative experiences of parents towards education, it is clear that parents with negative attitudes towards education, discourage their children from performing well at school.

On the other hand, the negative and harmful attitudes towards education in our society remain a critical barrier to learning and development. The discriminatory attitudes resulting from prejudice against people on the basis of race, colour, sex, language, class, culture, disability, religion, ability and other characteristics manifest themselves as barriers to learning when such attitudes are directed towards learners in the education system. Closely linked to the discriminatory attitudes based on various status is the labeling of different learners within the system of education who are designated as drop-outs, failures, repeaters, slow learners or borderline individuals. While it is of greatest importance to recognize the impact which this kind of labelling has on the learner's self-esteem, the most serious consequence of such labelling results when it is linked to placement or complete exclusion from the education system. The classification goes so far as to sometimes categorise learners, particularly those with severe mental disabilities, as being 'ineducable'. Such a label fails to take into consideration what is needed from the education system in order to meet these learners' needs, whatever their potentials and capacity.

Sometimes negative attitudes and labelling result from fear and lack of awareness about the special needs of learners or the potential barriers which they may face The notion of excluding learners who are HIV positive from attending school with other learners results from the negative assumptions and misconceptions associated with the Aids and HIV epidemic. Through ignorance of Aids and its transmission, these learners who are HIV positive are seen to place other learners at risk of infection. There are also barriers resulting from fear and lack of awareness which may arise from the feelings of parents and educators.

For example, learners who are genius or mentally superior are often regarded as a threat and therefore face denial of their significant abilities. For exceptional learners, fear and lack of awareness about disability among some parents, educators and learners remain the significant barriers to their learning and development. Such barriers may arise when the child is born with disabilities, as both parents have difficulty in accepting a child with a disability. The isolation and marginalisation of the disabled children are exacerbated when and if they are able to enter in the education system. Very often teachers fear the inclusion of a child with a disability in their class and respond negatively to their attendance. The negative attitudes towards the disabled learner are perpetuated by other learners who further alienate him or her. Many of the negative attitudes towards disability result from some traditional and religious beliefs which denigrate disability.

3.10.6 INFLEXIBLE CURRICULUM

The inflexible nature of the curriculum which fails to meet the diverse needs of learners, aspirations and values of the society becomes a serious barrier to learning and development. The key components of the curriculum include the style and tempo of teaching and learning, the learning content, the way the classroom is managed and organized, as well as material resources and equipment which are used in the learning and teaching process.

The curriculum implementation and an educator with inadequate training are never reconcilable. Sometimes educators, often through inadequate training, use teaching methods which may not meet some of the learners' needs. An educator may teach at a rapid pace which only accommodates gifted learners, or the pace and method of teaching may limit the initiative and involvement of the mentally superior learners. The scope and content or the subjects which learners are able to choose may limit the learner's knowledge base or fail to develop the intellectual and emotional capacity of the learner. Such barriers arise when sufficient attention is not given to balancing skills which prepare learners for work (vocational skills) and skills which prepare the learner for coping with everyday life (lifeskills). Some learners are excluded from certain aspects of the curriculum through ignorance or prejudice. For example, learners with physical disabilities are not given the chance of playing sports. Similarly, male and female

learners are encouraged to take certain subjects at school or at tertiary level according to their gender because those subjects will equip them for jobs which stereotypically are undertaken by men or women.

The inadequate provision of the necessary assistive devices which would equip the disabled learners to participate in the learning process, prevent them from accessing curriculum. The educators themselves may also prevent learners with disabilities from accessing the curriculum when they do not have special training in handling the handicaps, are not skilled to teach Braille or use audio equipment, and when educators are unable to counsel and work with parents as well, in order that these learners will achieve ultimate permanent vocational placement. The ability of curriculum to lead to learning breakdown also occurs through the mechanisms which are used to assess learning outcomes. Assessment processes are often inflexible and designed to only assess particular kinds of knowledge and aspects of learning, such as the amount of information that can be memorized rather than the learner's understanding of the concepts involved. The seriousness of such barriers is most obvious where there are a large number of learners who are forced to repeat aspects of the curriculum.

3.10.7 LANGUAGE AND COMMUNICATION

A further area of barriers arising from the curriculum, are those which result from the medium of teaching and learning. The didactic situation for the majority of learners occurs through a language which is not their first language. This not only places these learners at a disadvantage, but it also leads to linguistic difficulties which result in barriers to effective communication, hence learning breakdown takes place. Furthermore, educators often experience difficulties in developing appropriate support mechanisms for second language learners.

The barriers resulting from the medium of teaching and learning can be particularly destructive for Deaf learners whose first language is Sign Language. Misperceptions with regards to the morphological, syntactic, discourse, pragmatic, 'phonological' and semantic structures of Sign Language, which are entirely equal in complexity and richness to that which is found in any spoken language, often lead to Deaf learners being forced into learning through the so-called 'oral' method, or having to learn through signed spoken languages; for example, signed English or signed exact English. Being able to access Sign Language as the medium of teaching and learning enables these learners to develop bi- and multi-linguilism through Sign Language as the medium of teaching and learning.

Communication is essential for learning and development in both formal and informal contexts. Learners who are non-speaking due to the severity of their physical, intellectual and/or mental disability experience enormous barriers to learning and development. These barriers arise from the general unavailability of augmentative and alternative communication (AAC) strategies to enable them to engage in the learning process, and more often than not find themselves totally excluded from learning and development experiences. AAC systems could consist of alternative communications systems, supplements to vocal communication and communication through facilitators.

3.10.8 INACCESSIBLE AND UNSAFE BUILT ENVIRONMENT

In many contexts the vast majority of centres of learning are physically inaccessible to a large number of learners, educators and communities. Inaccessibility is particularly evident where centres are physically inaccessible to learners, educators and members of the community with disabilities who use wheelchairs or other mobility devices. Such inaccessibility often also renders centres unsafe for blind and Deaf learners.

3.10.9 INAPPROPRIATE AND INADEQUATE PROVISION OF SUPPORT SERVICES

Inappropriate or inadequate support services may contribute to learning breakdown or exclusion. For example, where the nature of the service is focused on problems in the learner rather than in the system where the barrier may exist - such as poor teaching methods - the intervention may exacerbate the learning breakdown. Similarly, the nature of the intervention may lead to a learner being removed from a learning environment rather than addressing the problems which may exist in that environment. Learners who may require individualized intervention to address barriers to learning may also not have access to these.

One of the key contributing factors to inappropriate and inadequate support provision relates to the nature of human resource development of both educators and personnel who provide services to learners and their families. A lack of awareness, service provision which is fragmented and inappropriate to the context in which it takes place, demoralization and a fear of dealing with a diverse range of needs all result from inadequate and fragmented development of human resources. Not only does poor provision in this area lead to a dearth of necessary skills and knowledge but it also contributes to a system, which is unable to meet a diversity of learner needs and prevent barriers to learning and development.

3.10.10 LACK OF ENABLING AND PROTECTIVE LEGISLATION POLICY

Many of the barriers to learning and development discussed above do not merely arise from problems occurring in education system or in the wider society. It is often policy and legislation governing the education system and regulating the society, which directly or indirectly facilitate the existence of such barriers. Where such legislation or policy fails to protect learners from discrimination or perpetuates particular inequalities, it directly contributes to the existence or maintenance of such barriers. For example, policy which is inflexible regarding issues such as age limits may prevent learners from being able to enter or continue in the education system, thus leading to exclusion. Similarly, legislation which fails to protect learners from discrimination and fails to provide for minimum standards which accommodate diversity allows for individual practices which may inhibit learner development or lead to provision which is inadequate and inappropriate for the needs which exist.

3.10.11 LACK OF PARENTAL RECOGNITION AND INVOLVEMENT

The active involvement of parents and the broader community in the teaching and learning process is central to effective learning and development. Such involvement includes recognition for parents as the primary care givers of their

children and as such, that they are a central resource to the education system. More specifically, they are critical components for effective governance of centres of learning and for facilitating community ownership of these facilities.

Where parents are not given this recognition or where their participation is not facilitated and encouraged effective learning is threatened and hindered. Negative attitudes towards parental involvement, lack of resources to facilitate such involvement, lack of parent empowerment and support for parent organisations, particularly in poor communities, all contribute to a lack of parental involvement in centres of learning.

3.10.12 DISABILITY

For most learners with disabilities, learning breakdown and exclusion occurs when their particular learning needs are not met as a result of barriers in the learning environment or broader society which handicap the learner and prevent effective learning from taking place. Having said this, however, particular impairments may prevent the learner from engaging continuously in structured learning and development. Such impairments may render the learner unable to participate in an ideal process of learning. For example, disabilities such as schizophrenia, severe autism, severe intellectual disabilities or multi-disabilities may prevent the learner from being able to continuously engage in programmes aimed at

facilitating learning and development. Some learners also experience learning breakdown due to intrinsic cognitive or learning difficulties in areas such as in acquiring skills in literacy or numeracy or in the organization or management of their own learning.

3.10.13 LACK OF HUMAN RESOURCE DEVELOPMENT

The development of educators' service providers and other human resources is often fragmented and unsustainable. The absence of on-going in-service training of educators; in particular, often leads to insecurity, uncertainty, low self-esteem and lack of innovative practices in the classroom. This may result in resistance and harmful attitudes towards those learners who experience learning breakdown or towards particular enabling mechanisms.

In addition to the aforementioned barriers, lack of access to traditional medicine to accommodate the diversity of the learners' needs must be born in mind.

3.10.14 LACK OF ACCESS TO TRADITIONAL MEDICINE

One of the most significant barriers to learning remains the inability of learners to access the traditional medicine which will contribute in the cultural solutions of

some existing problems which include the entire school community's beliefs and patterns of behaviour.

According to Karim et al., (1994:2) 80% of the South African population visit traditional healers for both medical, psychological and spiritual healing. Although various types of traditional practitioners play an important role in shaping beliefs and providing primary health care in communities, the provision of traditional medicine within the education system has not been even under consideration to accommodate diversity of cultures, despite the fact that it's contribution to overcoming cultural barriers to learning and development remains important.

3.11 OVERCOMING BARRIERS TO LEARNING AND DEVELOPMENT

Overcoming barriers to learning and development is a primary objective of the department of education, school managers, educators, school governing bodies, learners and communities at large. The barriers which those people involved in education attempt to eradicate or prevent evolve from an infinite variety of sources. Most barriers have complex origins and require systematic thought, planning, and action to be minimized. However, many barriers affect several people, or even society as a whole. These barriers to learning and development can be overcome efficiently and effectively through mechanisms that are structured into the system. Such mechanisms must develop the capacity of the system to

overcome barriers which may arise, prevent barriers from occurring, and promote the development of an effective learning and teaching environment.

Central to the development of such capacity is the ability to identify and understand the nature of the barriers which cause learning breakdown and lead to exclusion. Over and above this, however, such capacity requires a commitment to using and learning from practices and processes which exist within the system itself and which have been used or can be used to break down barriers and meet the range of needs of learners.

With these considerations in mind the NCSNET/NCESS has seen its responsibility as being to not only identify and analyse the barriers to learning in the South African education system, but also to identify those mechanisms already in the system and those which need to be developed which will enable diversity to be accommodated in an integrated system of education.

Such mechanisms will include: initiatives aimed at providing for learners who have been excluded from the system by both the state and non-governmental organizations; innovative practices for recognizing and accommodating diversity; activities that advocate against discrimination and challenge attitudes; processes towards the involvement of learners, parents, educators and community members in the governance of centres of learning; training programmes which equip

educators to deal with diverse needs; curriculum restructuring to suit the needs of the society as a whole, the interest, abilities, skills and needs of an individual learner; organisation and development of teaching and learning environments; as well as economic and political transformation supported by enabling and protective legislation and policy.

The success of overcoming barriers to learning and development depends on the schools and the parties involved in education, who are aware of the seriousness of learning barriers, and support the provision of education support services to eradicate barriers to learning and development of learners. The education support services are provided to revitalize the school system and enable schools to deliver an improved quality of education to learners and, as a result, to strengthen the social and economic structures of the district, region, province or the country.

3.12 THE NATURE AND PROVISION OF SUPPORT SERVICES

Education support services are vitally important. They are aimed at ensuring that the child attending school is protected against any barriers to learning and development, so that he can obtain the maximum benefit from the learning experiences provided by the school. The education support services are part and parcel of primary health care. The major reason of providing education support services for the learners attending educational institution is the object of the

service to recognize the barriers which may exist or arise so that these can be removed, prevented or at least minimized in good time. This will prevent or reduce frequent absence from school for health reasons and prevent the development of anti-social behaviour due to the frustration of being unable to keep up with others and even dropping out of school altogether.

Education support services depend largely on the education support personnel drawn from the various departments of education, health and social welfare, have included psychologists, social workers, remedial or learning support teachers, guidance and counselling teachers, speech and hearing/language and listening teachers, physiotherapists, occupational therapists, speech therapists, doctors and nurses. The non-governmental organisations and other community-based resources such as peer counsellors, community leaders, traditional healers and parents can be used to render education support services. It is the duty of the Department of Education with other different provincial and regional departments of education to ensure that education support services are maximally provided in all educational institutions, and, that education support personnel implement education support services and ensure that learners make optimal use of them.

3.13 CONCLUSION

In this chapter the role of traditional medicine in a changing society was discussed. The discussions focused on the influence that changes in society had on the traditional curers regarding their traditional medicine. The following chapter will give a full explanation of the methodology, presentation, analysis and interpretation of data.

CHAPTER FOUR

4.0 METHODOLOGY, PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

4.1 INTRODUCTION

The complexity of certain personal, academic and social problems experienced by learners warrant a procedure to be followed for the investigation of traditional medicine use within the school situation. There are incidences in our educational institutions (as discussed in chapter one 1.1 and chapter two 2.8.2) which highlight the importance of incorporating traditional medicine in the South African Education Support Services.

It is a generally held belief among certain communities in the Republic of South Africa that certain illnesses need traditional medicine for treatment. The combinations of Western medicine and African traditional medicines are often applauded in such communities. Research evidence which has appeared on traditional medicine in South Africa is pertinent to the present investigation. Studies which have been conducted in this context are difficult to classify in separate categories. There are numerous avenues to investigating traditional medicine. One way is to analyse the role functions of traditional healers (Buhrmann, 1977, Sokhela, Edwards & Makunga, 1984; Griffiths & Cheetham, 1982, Editorial, 1982; Machlean & Bannerman, 1982) The

second approach focuses on the traditional practice of medicine and the integration of traditional and western medicines (Conco, 1982; Rappaport & Rappaport 1981; Farrand, 1984; Holdstock, 1979; Green & Makhulu, 1982). Perhaps the abundance of literature in this domain comes from research on traditional theories of illness and treatment modalities among indigenous healers (Edwards, Grobelaar, Makunga, Sibaya, Nene, Kunene & Magwaza, 1983; Murdock, Wilson & Frederick, 1980; Edwards, Cheetham, Majozi & Lasich, 1982; Pearce, 1982).

The prospect or potential for a health care partnership between traditional healers and Western physicians has become topical in recent developments in South Africa and other countries (Karim, Arendse & Ziqubu, 1994; Bannerman, Burton & Wen-Chieh, 1983; Chipfakacha, 1994; Crawford, 1995; Kelly, 1995; Mabina, Moodley & Pitsoe, 1997; News and Comment, 1987; Mercury correspondent, 1999).

For the present investigation the use of traditional medicine in the education support services is pivotal. The events which took place within certain schools as discussed in the previous chapters, illustrate the need for this study to be undertaken. This chapter deals with the various methods in which data were collected, presented, analysed and interpreted.

4.2 *METHODOLOGY*

In conducting this research study, the researcher compiled the research proposal for the entire investigation. After explaining the motive for the study to be undertaken, identifying and defining the statement of the problem, and defining the concepts in the topic, the following objectives of the study were identified:

4.3 THE AIMS OF THE STUDY.

These objectives of this study show the directions to be adhere to; namely:

4.3.1 To determine the nature of teachers' perceptions of the need for traditional medicine in schools.

4.3.2 To investigate the nature of learners' problems which require traditional medicine in schools.

4.3.3 To identify procedures that can be followed to provide traditional medicine to meet learners' needs.

4.3.4 To provide guidelines in traditional medicine intervention within a school.

4.3.5 To find out whether teachers' perceptions of traditional medicine in schools are influenced by the following teacher characteristics:

4.3.5.1 Age,

4.3.5.2 Religious affiliation,

4.3.5.3 Qualifications,

4.3.5.4 Experience,

4.3.5.5 Sex.

4.3.6 To find out whether there is any agreement among ranks assigned by the respondents to:

4.3.6.1 job opportunities amenable to creation through the use of traditional medicine.

4.3.6.2 afflictions amenable to treatment by traditional medicine.

4.4 HYPOTHESES.

The theoretical hypotheses formulated were:

4.4.1 Teachers do not differ with regard to:

4.4.1.1 their perceptions of the need for traditional medicine practices in schools.

4.4.1.2 their perceptions of the nature of learners' problems which require traditional medicine.

4.4.1.3 procedures to be followed in the provision of traditional medicine in schools.

4.4.1.4 the nature of methods of interventions using traditional medicine within schools.

4.4.2 There will be no association between nature of perceptions and the following teachers' biographical data:

4.4.2.1 Age,

4.4.2.2 Religion,

4.4.2.3 Qualifications,

4.4.2.4 Teaching experience,

4.4.2.5 Gender.

4.4.3 There will be no correlation among ranks assigned by the teachers to:

4.4.3.1 job opportunities amenable to creation by traditional medicine.

4.4.3.2 afflictions amenable to treatment by traditional medicine.

4.5 METHODS AND PROCEDURES FOR DATA COLLECTION.

The data which were collected were derived from the educational research literature study, which entails the primary and secondary resources that have some bearing on the topic. The primary sources consisted of departmental commissions' reports, books and journals, which contain original research reports; whereas the secondary sources refer to the textbooks and other materials that give an overview of research

and ideas related to the educational topic covered. The data were also collected through especially designed research tools.

4.5.1 DATA COLLECTION TECHNIQUES.

A research study requires the use of one or more research instruments. The researcher took a decision to utilize personal observation, interviews and questionnaire as data collecting tools.

4.5.1.1 The questionnaire as a research technique.

As mentioned in paragraph 1.6.3 data was collected through the questionnaire technique. A questionnaire is a set of questions dealing with some topic or related group of topics, given to a selected group of individuals for the purpose of gathering data on a problem under considerations (Van Rensburg, Landman and Bodenstein 1994:504).

4.5.1.2 Rationale for choosing the questionnaire technique.

The researcher regarded the questionnaire as one of the most appropriate and relevant instrument to utilize in collecting data for this investigation. The use of a questionnaire as a research instruments is justified by Gay (1987:195) who states

that the use of a questionnaire has some definite advantages over other methods of collecting data; for example, a questionnaire is more efficient in that it requires less time, is less expensive and permits collection of data from a much larger sample. Hence, the use of the questionnaire as a research tool was justified by its ability to allow wide coverage with the less effort, minimum financial expenditure and time consumption.

The questionnaire method still continues to be, if properly constructed and administered, the best available instrument for obtaining information from widely spread course (Behr 1988:68). Because of the time constraints involved when interviews are conducted, it was practically impossible to interview many teachers and principals in various schools. In this research study, the researcher used less than thirty minutes to get each group of teachers and principal, in each school, to complete questionnaires.

The fieldwork was completed within a short period without disturbing the curricular programmes of the schools. The questionnaire method affords a good measure of objectivity in soliciting and coding the responses of the population sample (Ngcobo, 1986:150). Consequently, it was, for the aforementioned reasons and considerations that the questionnaire techniques was used in this research study.

4.5.1.3 Construction of the questionnaire.

The major purpose in construction of the questionnaire for this investigation was to motivate the subjects to communicate the required information. Considerable attention was taken with regard to the selection of the right content; suitable wording; context and sequence in the designing of the questionnaire.

One set of questions was designed for teachers. The questionnaire was constructed on the basis of the research objectives, and it consists of more closed questions with fewer open-ended questions. Most of the questions consisted of a list of alternative answers. This was appropriate because it is easier and quicker for the respondents to respond to closed questions than to other types of questions. It was imperative for the researcher to write the accompanying letter, instructions for questionnaire completion, and to formulate the questions in Zulu in order to avoid ambiguity, vagueness, bias, prejudice and technical language in the questions.

The questionnaire was sub-divided into Section A and Section B. Section A deals with the biographical information of the subjects; and Section B focused on traditional medicine. The questionnaire in Section B was designed so that the first part of the questions would be simple, have high interest value in order to encourage the respondents to participate. The middle part of the questionnaire consisted of slightly more difficult questions, whereas the last part of the

questionnaire contained questions which were less difficult in order to motivate the subjects to complete and return their questionnaires. Hence, the researcher presented the questions as simply, clearly and concisely as possible in order to minimize distortion. Consequently, the researcher produced a questionnaire design and layout which encouraged higher levels of response from the subjects. This is supported by Cohen and Manion (1980:111) who emphasize, "the appearance of the questionnaire is vitally important. It must look easy and attractive. A compressed layout is uninviting; a larger questionnaire with plenty of space for questions and answers is more encouraging to respondents."

4.5.1.4 Advantages of the questionnaire instrument.

Orlich (1978:7) states that for every advantage to a questionnaire survey, there is an accompanying disadvantage. A written questionnaire was used as one of the instrument to collect data in this study. It was necessary for the researcher to evaluate specific advantages for their suitability to the research question and the specific target population being studied, as well as relative cost involved. The researcher selected and took into account some of the following appropriate advantages of questionnaire use for this study as mentioned by Mahlangu, (1987:85-94), Norval (1988:60) and Orlich (1978:4).

(a) Advantages.

2. A questionnaire technique is less expensive to administer than using other types of technique to gather data
3. Many individuals may be contacted simultaneously, and persons in remote or distant areas are reached.
4. Each selected respondent receives identical questions because standard instructions are given to the respondents. Hence questionnaires provide greater uniformity across measurement situations than do interviews.
5. Questionnaires prevent interviewers' biases. The way the interviewer asks questions and even the interviewer's general appearance or interaction may influence respondent's answers.
6. Questionnaires permit a respondent a sufficient amount of time to consider answers before responding. As a result, respondents can complete questionnaires in their own time and in a more relaxed atmosphere.
7. Generally the data provide by questionnaires can be more easily analyzed and interpreted than the data obtained from verbal responses.
8. Data obtained from questionnaires can be compared and inferences made.
9. The administering of questionnaires, the coding, analysis and interpretation of data can be done without any special training

10. Questionnaires can elicit information which cannot be obtained from other sources. This render empirical research possible in different educational disciplines.
11. Through the use of the questionnaire approach the problems related to interviews may be avoided. Interview "errors" may seriously undermine the reliability and validity of survey results.
12. A questionnaires permit anonymity. If it is arranged such that responses were given anonymously, this would increase the researcher's chances of receiving responses which genuinely represent a person's beliefs, feelings, opinions or perceptions.

4.6 SAMPLE DESIGN.

This research project focused on the teachers from the various school levels; that is, junior and senior primary school teachers, junior and senior secondary school teachers in the KwaZulu Natal Department of Education and Culture. All these schools have common characteristics in the Province of KwaZulu Natal at large. The selection of school teachers is preferable because of the following three reasons:

1. The present investigation deals with the prospect and scope for traditional medicine in the South African education support services.

2. It is often alleged that certain personal, academic and social problems in our educational institutions need intervention by adult members of the community. Such community intervention with educational problems might include pupils, teachers and parents. The involvement of these community members will always reflect convictions, beliefs and cultural patterns of behaviour. Behaviour patterns may include the use of medicine.
3. The mysterious attacks or hysterical attacks and other 'African illnesses' are common at our schools. Therefore, there is a need for research to be conducted on teachers' perceptions of traditional medicine use in the education support services

.

The Department of Education and Culture has eight regions in the Province of KwaZulu Natal. Each region is divided into different district offices. There are various circuits in each district office. The researcher chose two district offices; namely, Umbumbulu District and Umlazi South District from the South Durban Region, one district office; that is, Ndwedwe District from the North Durban Region and one district office; that is, Lower Tugela District from Empangeni Region. Two circuits were selected from Umbumbulu District, one circuit from Umlazi South District, two circuits from Ndwedwe District, and one circuit from Lower Tugela District, respectively.

TABLE 4.1 SHOWS THE NUMBER OF REGIONS, DISTRICTS AND CIRCUITS CHOSEN.

REGIONS	DISTRICTS	CIRCUITS
South Durban	Umbumbulu	Folweni
		Umbumbulu Central
	Umlazi South	Udukumbane
North Durban	Ndwedwe	Ndwedwe East
		Tongaat
Empangeni	Lower Tugela	Umhlali

There was no need for the researcher of this study to select the sample from all the regions in the Province of KwaZulu Natal because besides the time and financial constraints involved, the schools that were selected within the circuits are those that are in the rural, semi-urban and urban areas. Hence, six circuits selected from three districts formed clusters and a sample could be drawn. Each cluster (circuit) has different characteristics because teachers differ in age, gender, religion, qualifications, teaching experiences and other personal characteristics; the cluster has also various types of school levels; namely, junior and senior primary

schools, and junior and senior secondary schools. The circuits (clusters) have also similar characteristics.

4.7 ADMINISTRATION OF THE QUESTIONNAIRE AS THE RESEARCH INSTRUMENT.

The researcher had to adhere to the procedures for the administration of the research instrument as discussed in chapter one, before undertaking the field investigation. A covering letter was designed to accompany the questionnaires which were delivered to and collected from the teachers of the schools chosen. The major aim of the covering letter was to indicate the main purpose of the research study; that is, to convey the message of its importance and to give the respondents an assurance of confidentiality and to motivate them to complete and return the questionnaires. Gay (1987:198) asserts that it is essential that every questionnaire be accompanied by a covering letter that explains what is being asked of the respondent and why.

4.8 PILOT WORK.

Most researchers emphasize the value of pre-testing the questionnaire on a small population before research techniques can finally be put into operation, known as pilot study, pilot work or pilot run. The pilot study is an abbreviated version of a research project in which the researcher practises or tests the procedures

to be used in the subsequent full-scale project (Dane, 1990:42). It was therefore necessary that pilot work be conducted because it is a trial-run which assists the researcher to take a decision whether the research project is feasible and whether it is worthwhile to proceed. For the purpose of this study, the researcher conducted a pilot study on a combined higher primary and high school teachers.

The researcher took into consideration the following purposes of pilot work, as described by some of the different researchers; namely:

2. A pilot study gives the researcher an idea of what the method will actually look like in operation and what affects (intended or not) it is likely to have. In other words, by generating many of the practical problems that will ultimately arise, a pilot study enables the researcher to avert these problems by changing procedures, instructions and questions (Mzulwini, 1996:101).
3. It provides an opportunity to assess the appropriateness and practicability of the data collection instruments (Ary 1990:109).
4. It attempts to determine whether questionnaire items meet the desired qualities of measurement and descriminability (Tuckman, 1972:225).
5. It is a preliminary step to avoid erroneous and insignificant hypotheses. It's main objective is to detect possible weakness relating to ambiguity due to poor morphological formulations (Goode and Hatt, 1959:147).

6. It determines whether the respondents could complete the questionnaire within a specified time limit (Mrwetyana, 1983:122).
7. It permits a thorough check of the planned statistical and analytical procedures, thus allowing an appraisal of their adequacy in treating the data (Plug, Meyer, Low and Gouws, 1991:49).

The researcher pre-tested the questionnaire to ensure that the questions would comply with the requirements of the research project.

4.9 THE STUDY SAMPLE.

The sample design has been discussed in this chapter. The selection of a sample is a very important step in conducting a research study. A good sample is one that is representative of the population from which it was selected (Gay 1987:103). The population of this research investigation comprised all Black school teachers in the Province of KwaZulu Natal. The researcher would have wished to include all Black school teachers. However, because of the limited time, limited resources and cost involved, the researcher had to limit this investigation to ten schools within six circuits as shown in Table 4.1. Hence, the researcher took a decision to make use of the cluster sampling technique which, according to Cohen et al; (1989:109), involves collecting information from a smaller group or subset of the population in such a way that the knowledge gained is representative of the total

population. The researcher chose cluster sampling because of the number of Black school teachers which is large and widely spread over the Province of KwaZulu Natal.

The district offices; namely, Umbumbulu District, Umlazi South District, Ndwedwe District and Lower Tugela District which were selected, were taken as clusters. This means that two circuits selected from Umbumbulu District, one circuit selected from Umlazi South District and two circuits selected from Ndwedwe District and one circuit selected from Umhlali Circuit, were regarded as a cluster. In each district office, the researcher selected randomly the schools of circuits within a cluster. The table below shows the selection of schools for the study sample.

TABLE 4.2 SHOWING THE TYPES OF SCHOOLS VISITED.

SCHOOL CATEGORY	NUMBER OF SCHOOLS SELECTED	NUMBER OF TEACHERS (SAMPLE)	NUMBER OF TEACHERS RESPONDED
Junior Primary Schools	2	18	10
Senior Primary Schools	2	15	7
Combined Primary Schools	2	19	10
Junior Secondary Schools	2	22	15
Senior Secondary Schools	2	28	24
Total	10	102	66
Percentage		100%	65%

Table 4.2 shows the types of schools which were selected within the circuits as indicted in **Table 4.1**, and the number of teachers that were visited in their respective schools. This present study investigated traditional medicine in the South African education support services. Hence, the sample comprised teachers from various types of schools. There are ten different schools which were selected . A 65% return rate was obtained with 66 out of 102 questionnaires completed and returned.

4.10 PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

In this section, the aim is to show how the data collected by means of a questionnaire were analysed.

4.10.1 METHOD

4.10.1.1 FINAL STUDY SAMPLE

The subjects were male and female teachers of KwaZulu Natal junior and senior primary schools, junior and senior secondary schools. This was an accidental sample (N=66). Only those teachers who were willing to complete the questionnaire were included in the sample. A nonprobability sampling design was used.

4.10.1.2 INSTRUMENT AND PROCEDURES

A Likert scale was constructed to measure the areas indicated by the aims of study. This is a unidimensional five-point scale in which a score of (5) five is assigned to strongly agree and a score of (1) one to strongly disagree with each statement. A high total scale score indicates teachers' positive perceptions of the use of traditional medicine within the school and a low score, the opposite. (The scale also required the subjects to construct a rank-order of illnesses and events amenable to treatment by traditional medicine). The research instrument was administered by the researcher after establishing rapport with the respondents and explaining the purpose of the study.

4.10.2 RESULTS

The hypotheses to be tested are the following:

Hypothesis number one:

Teachers do not differ with regard to their perceptions of the need for traditional medicine practices in schools.

Hypothesis number two:

Teachers do not differ with regard to their perceptions of the nature of learners' problems which require traditional medicine.

Hypothesis number three:

Teachers do not differ with regard to procedures to be followed in the provision of traditional medicine in schools.

Hypothesis number four:

Teachers do not differ with regard to the nature of methods of intervention using traditional medicine within schools.

Hypothesis number five:

There will be no association between nature of perceptions and the following teachers' biographical data:

5.1 Age,

5.2 Religion,

5.3 Qualifications,

5.4 Teaching experience,

5.5 Gender.

Hypothesis number six:

There will be no correlation among ranks assigned by the teachers to:

6.1 job opportunities amenable to creation by traditional medicine.

6.2 afflictions amenable to treatment by traditional medicine.

4.10.2.1 ANALYSIS OF DATA

(a) TESTING OF HYPOTHESIS NUMBER ONE

The study was conducted to find answers to the six aims. The first aim was to determine the nature of teachers' perceptions of the need for traditional medicine in schools.

There were fifteen items of Likert type scale designed to measure responses to aim number one. This was a unidimensional scale which was scored 5,4,3,2, and 1 for strongly agree, agree undecided, disagree and strongly disagree respectively. Therefore the highest possible score was 15 X 5 = 75 and the lowest possible score was 15. A total score for each respondent was found by summating scores to individual items. The total scores for all respondents (N=66) were added and divided by the number of cases to find the average. A high score on this scale indicated positive perceptions about the need to use traditional medicine in the school. The opposite held true for the low score in this scale. Those who obtained total scores equal to and above the mean were classified as positive and those who obtained total scores below the mean were classified as negative.

This dichotomy led to the establishment of two cells with a frequency of 26 and 40 below and above the mean respectively. A chi-square test of 2 97 at df. = 1 and 5% level was not significant ($p>0.05$). This means that teachers did not differ with regard to their

perception of the nature of need for traditional medicine in schools. Hypothesis number one has been confirmed.

(b) TESTING OF HYPOTHESIS NUMBER TWO

The results were statistically significant with regard to the teachers' views on the learners' problems which require traditional medicine (A chi-square of 3.878 at df = 1 was significant ($p < 0.05$. Teachers did differ in their views on the nature of problems which need the use of traditional medicine in schools. Hypothesis number two was therefore not confirmed.

(c) TESTING OF HYPOTHESIS NUMBER THREE

The third hypothesis on the procedures that can be followed in providing traditional medicines within the school situation was disconfirmed . A chi-square of 4.908 at df = 1 was statistically significant at the 0.05 level, ($p < 0.05$). Teachers disagreed with regard to procedural provisions of the traditional medicine in schools.

(d) TESTING OF HYPOTHESIS NUMBER FOUR

The fourth hypothesis was confirmed. Teachers did not differ with regard to the methods that can be followed in the use of traditional medicine within the school A chi-square of 2.18 a *df* = 1 was not significant ($p > 0.05$)

(e) TESTING OF HYPOTHESIS NUMBER FIVE

The fifth hypothesis is subdivided into several units as shown in the accompanying tables.

Table 4.3: The relationship between age and perception (N = 66)

AGE RANGE	PERCEPTION	
IN YEARS	NEGATIVE	POSITIVE
20 – 24	2	2
25 – 29	1	10
30 – 34	7	10
35 – 39	10	7
40 – 44	5	4
45+	1	7

$\chi^2 = 10.52$ df = 5 p < 0 05

The association between age and perception is significant. The perception of the need for the use of traditional medicine within the school was associated with the age of the respondent. About 61% of the respondents held positive perceptions about the use of traditional medicine in schools. The hypothesis that the variable of age was associated with perceptions of the need for the traditional medicine in schools was confirmed.

Table 4.4: The relationship between religious affiliation and perception (N = 66)

RELIGIOUS SECTS	PERCEPTION	
	NEGATIVE	POSITIVE
CHRISTIAN CHURCHES	13	21
INDEPENDENT MOVEMENT	12	16
UNDIFFERENTIATED SECTS	2	2

$\chi^2 = 12.80$ $df = 2$ $p < 0.05$

The relationship between religion and perception was found to be significant. Contrary to expectation, the followers of Christian and Independent religious sects perceive the use of traditional medicine within the school positively. The hypothesis that religious affiliation was positively associated with perception of the use of traditional medicine in schools was upheld. The undifferentiated group of teachers was indifferent towards the use of traditional medicine. The hypothesis on association between religion and perception was retained.

Table 4.5: The relationship between qualification and perception (N = 66)

TEACHER'S QUALIFICATIONS	PERCEPTION	
	NEGATIVE	POSITIVE
POSTGRADUATE & TEACHERS' DIPLOMA	2	3
DEGREE & TEACHERS' DIPLOMA	3	9
UNDERGRADUATE	1	0
TEACHERS' DIPLOMA ONLY	20	28

$\chi^2 = 2.63$ $df = 3$ $p > 0.05$

The level of education did not influence perception of the need for traditional medicine. The results are not statistically significant. Teachers did not differ in their perceptions of the need to use traditional medicine in schools as a function of their educational level. The hypothesis of no association between these variables was, therefore, upheld.

Table 4.6: The relationship between teaching experience and perception (N = 66)

YEARS OF TEACHING EXPERIENCE	PERCEPTION	
	NEGATIVE	POSITIVE
0 – 7	8	12
8 – 14	9	12
15 – 21	8	10
22 – 28	1	6

$\chi^2 = 0.54$ df = 1 $p > 0.05$

Table 4.6 shows that years of teaching experience did not influence teachers' perceptions. Teachers belonging to different age groups did not differ in their perceptions of the need to use traditional medicine in the school. Teachers were positively inclined towards the use of traditional medicine. Very few teachers held negative perceptions on this matter. The statistical results were not significant and therefore the hypothesis of no association between the variable of age and perception was retained

Table 4.7: The relationship between gender and perception (N = 66)

GENDER	PERCEPTION	
	NEGATIVE	POSITIVE
MALE	10	18
FEMALE	17	21

$\chi^2 = 0.54$ df = 1 $p > 0.05$

Table 4.7 shows that male and female teachers did not differ in their perceptions of the need for traditional medicine in schools. The hypothesis was therefore accepted. There was no association between the variable of gender and perception of the use of traditional medicine within the school.

(f) TESTING OF HYPOTHESIS NUMBER SIX.

Table 4.8: The degree of agreement among ranks assigned to afflictions and job opportunities.

CRITERION	ΣD^2	M^2	N^2	N	W	χ^2	DF	α
JOB OPPORTUNITIES	604	1089	125	5	0.06	7.77	4	P>0.05
AFFLICTIONS	7491	2209	343	7	0.12	33.86	6	P<0.05

(Siegel, 1956; Behr, 1988)

The present study aimed also to find out whether there was any correlation among ranks assigned by respondents to different types of afflictions and job opportunities. These afflictions and job opportunities were put as events amenable to treatment by traditional medicine. The question, specifically was: Is there any correlation in the ranking of the seven illnesses by the teachers and five job opportunities depicted as amenable to treatment by traditional medicine.

The probability associated with a chi-square of 7.77 at df = 4 (table 4.8) can occur by chance between 10 and 20 times out of a hundred It was not significant at the

chosen level of significance. The hypothesis that there would be no agreement among ranks assigned to different job opportunities was therefore upheld. Teachers did not agree with the extent to which traditional medicine could be used to create job opportunities in the teaching profession

The probability associated with a chi-square of 33.86 at df = 6 can occur by chance beyond 0.001 level. It is highly significant at the chosen level of significance. The hypothesis that there would be no agreement among ranks assigned to different afflictions has not been confirmed. Teachers did agree with regard to the extent to which traditional medicine can be used in the treatment of seven different afflictions. The coefficient of concordance W indicates the strength of association among the teachers in the ranking of illnesses or afflictions which can be treated through the use of traditional medicine (W = 0.12).

One way to interpret the value of W would be to consider it as high or low. With regard to job opportunities the association with traditional medicine could be regarded as extremely low (W=0.06) The association between the use of traditional medicine and the nature of illness was relatively low (0.12). In both instances it can be deduced that teachers did not use the standard criterion in their judgement or ranking. In the case of illnesses, there was a low to moderate degree of correlation or association or agreement among the judges or teachers. This association was significant and persisted beyond the 5% level of significance

4.11 CONCLUSION

Chapter four discusses methodology and the data obtained from the completed questionnaire. The data was presented, analysed and interpreted. The hypotheses were tested and the results were presented. The next chapter will consist of the discussion of the findings, summary and limitations of the study, and recommendations.

CHAPTER FIVE

5.0 FINDINGS, SUMMARY AND LIMITATIONS OF THE STUDY, AND RECOMMENDATIONS

5.1 INTRODUCTION

In this present chapter attention is directed at the discussion of the findings of the study. This discussion of findings is based on the results as presented in the previous chapter (cf. 4.10.2). This will be followed by the summary of the literature study and empirical investigation. The limitations that emanate from this study will be discussed, and recommendations will be formulated.

5.2 THE AIMS OF THE STUDY

Specific aims (cf.1.9) channelled the direction of this study. These aims were realized through a literature study together with an empirical survey consisting of structured questionnaires, informal, unstructured and structured interviews and observations. The findings are based on the following questions:

5.2.1. What is the nature of teachers' perceptions of the need for traditional medicine in schools?

5.2.2. What is the nature of learners' problems which require traditional medicine in schools?

5.2.3. What are the procedures that can be followed to provide traditional medicine to meet learners' needs?

5.2.4. What are the guidelines to be provided for traditional medicine intervention within a school?

5.2.5. Is there a relationship between teachers' perceptions and the following teachers' characteristics:

5.2.5.1 Age,

5.2.5.2 Religious affiliation,

5.2.5.3 Qualifications,

5.2.5.4 Experience,

5.2.5.5 Sex.

5.3 DISCUSSION OF FINDINGS

A relatively small sample size was used in this study. The findings of this study should be regarded as exploratory and essentially tentative. Further studies should use large samples and standardized research instrument to allow scientifically solid explanations. While it did not quite reach the accepted significance levels, the present study revealed the following findings:

5.3.1 FINDINGS WITH REGARD TO THE NATURE OF TEACHERS' PERCEPTIONS OF THE NEED FOR TRADITIONAL MEDICINE IN SCHOOLS

The important finding was that teachers did not differ with regard to their perception of the nature of the need for traditional medicine in schools (cf. 4.10.2.1). The teachers endorsed scale items on positive rather than negative. This finding came as no surprise because many studies in South Africa have demonstrated the use of traditional medicine with convincing regularity (Edwards et al.,1983; Farrand, 1984; Conco et al ., 1984).

5.3.2 FINDINGS WITH REGARD TO THE NATURE OF LEARNERS' PROBLEMS WHICH REQUIRE TRADITIONAL MEDICINE IN SCHOOLS

The findings are of utmost importance with regard to the teachers' opinions on the learners' problems which require traditional medicine. Teachers differed in their views on learners' problems which would require treatment by traditional medicine (cf. 4.10.2.1). This is understandable in the light of different procedural modes of the use of traditional medicine. The same illness can be treated differently within the paradigm of traditional medicine (Holdstock, 1979; Sokhela et al., 1983).

5.3.3 FINDINGS WITH REGARD TO THE PROCEDURES THAT CAN BE FOLLOWED TO PROVIDE TRADITIONAL MEDICINE TO MEET LEARNERS' NEEDS

The findings with regard to the procedures that can be followed to provide traditional medicine to meet learners' needs were negative. The teachers disagree with regard to procedural provisions of the traditional medicine in schools (cf. 4.10.2.1). This is acceptable because traditional assessment and treatment of afflictions are usually carried out by one or more of the three broad categories of practitioners namely, faith healer/prophet (umthandazi), the traditional diviner (isangoma) and doctors (izinyanga) (Edwards et al., 1983). A recent study, however, has revealed that patients who describe themselves as suffering from "*AMAFUFUNYANA*" have shifted their preferred services from traditional healers to use of psychiatric services (Lund & Swartz, 1998). Most of these studies' findings are influenced by the method of investigation and researchers' attitudes.

5.3.4 FINDINGS WITH REGARD TO THE GUIDELINES IN TRADITIONAL MEDICINE INTERVENTION WITHIN A SCHOOL

The most important finding is that teachers did not differ with regard to the guidelines that can be followed in the use of traditional medicine with the school (cf. 4.10.2.1).

5.3.5 FINDINGS WITH REGARD TO THE TEACHERS' PERCEPTIONS OF THE NEED FOR THE USE OF TRADITIONAL MEDICINE IN RELATION TO THEIR CHARACTERISTICS

While teachers' qualifications, experience and gender did not significantly influence teachers perceptions in this regard, age and religion did influence teachers' perceptions of the need for traditional medicine (cf. 4.10.2.1). This latter finding is consistent with western and traditional practitioners' support for integration of these approaches in South Africa (Hopa, Simbayi & du Toit, 1998). Traditional healing is gradually making inroads as an integral part of health care in this country. Hopa et al., (1998) reviewed extensive literature which advocates collaboration of Western and traditional health systems.

Two reasons can be proposed to account for the support of traditional medicine in the South African education support services. One is that Western medicine has become too expensive for the average wage earner or unemployed black South African. Whether this proposal is one which regulates the behaviour of employed African teachers is a matter of conjecture. Alternatively, the use of traditional medicine is interwoven with cultural beliefs, practices, religion and customs among South Africans. Literature is found in abundance which bears testimony to this assertion (Edwards et al., 1983; Dommisse, 1987; Edwards, 1986; Editorial, 1982; Green and Makhulu, 1982; Pearce, 1982).

5.3.6 FINDINGS WITH REGARD TO THE AGREEMENT AMONG RANKS ASSIGNED TO JOB OPPORTUNITIES AND AFFLICTIONS

In the present study it was decided to investigate teachers judgement of job opportunities which can be created through the use of traditional medicine or the application of the latter to the afflictions called "people's diseases". The respondents ranked events such as the use of traditional medicine and chances for promotion or appointment. Teachers assigned ranks ranging from one (most amenable to traditional medicine) to seven (least amenable). It is interesting to note that there was no agreement among ranks assigned to activities related to job opportunities. The correlation among ranks was significant for various types of

illnesses. Many of these afflictions are well known in traditional black culture. General belief system appears to influence perceptions, however subtle.

As with other biographical data, teachers qualifications, teaching experience and gender did not influence perceptions of the need for traditional medicine. In the domain of anthropological studies, researchers rarely manipulate variables (Hopa et al., 1998; Lund & Swarts, 1998; Edwards et al., 1983; Dommisse, 1986). Where such manipulation occurs, the study is neither retrospective nor ex post facto. It is therefore not an oversight to neglect statistical manipulation. From an holistic perspective it is highly unlikely to get a significant difference among groups when investigating aspects of tradition, beliefs and customs. An individual reacts as a totality to aspects which affect his/her cosmology.

5.4 SUMMARY OF THE STUDY

5.4.1 STATEMENT OF THE PROBLEM

This present research study investigated the prospect and scope for traditional medicine in the South African education support services. In essence, the study investigated the following problem areas:

5.4.1.1 What is the nature of teachers' perceptions of the prospect and scope of traditional medicine in the school situation?

5.4.1.2 Which type of illnesses, teachers believe require traditional medicine practices treatment procedures within the school?

5.4.1.3 What is the modus operandi that can be followed to effect traditional healing/treatment within a school?

5.4.1.4 Which guidelines will teachers recommend for implementation of traditional healing procedures within the school?

5.4.2 HISTORICAL BACKGROUND OF TRADITIONAL MEDICINE

As long as human exist, they shall be exposed to many different types of diseases. There are so many that it is difficult to put an accurate figure on the number of various diseases which have emerged throughout the world - but it runs into the billions. The treatments of diseases are effected either by the use of man's hidden spiritual powers or by the application of plants that have been found to contain healing powers or by both. There are various types of human communities, and the extent of their use of medicinal plants varies. It is of utmost importance to the members of every group to try to maintain their health, and to restore to health those who fall ill.

All human communities develop their own medicine in order to prevent and cure diseases to enhance health. The literature tell us about the origin and the development of medicinal systems, such as; Egyptian traditional medicine, Indian Ayurveda,

Moslem Unani; to mention a few examples. The foundation of medicine as known to the world was laid down by Egyptian Africans. The development of modern medicine, began later in Greece and other parts of the world. The Greeks started, scientific medicine through the Egyptians' foundation of medicine. The Egyptians' foundation of medicine was a source of the art of healing for mankind throughout the ages, and the fountain – head of the traditional and modern healing.

The published written sources of the world's medical systems have developed the new discipline of 'ethnomedicine', that is, those beliefs and practices relating to diseases which are the products of indigenous cultural development, and are not explicitly derived from the conceptual framework of scientific medicine.

5.4.3 TRADITIONAL MEDICINE IN A CHANGING SOCIETY

The challenge for health care reforms is not unique to South Africa. All over the world, fundamental assumptions are being reassessed in the quest for greater efficiency. Since the election of the new South African Government in April 1994, there have been increasing calls for partnerships between traditional healers and biomedical government health services. The collaboration between African traditional healers and biomedical personnel is a part of the South African political scene to the extent that it influences aspects of the South African constitution that was adopted in 1994. More recently, commendable individual and institutional attempts

at collaboration have been and still are being initiated in South Africa. For example; meetings, workshops and discussions are held all over the country between traditional healers and biomedical personnel in order to learn about each other's work and from each other. Health workers and education personnel should therefore encourage rapport between themselves and traditional healers.

Attempts to obtain more effective co-ordination of the education support services must be made in order to support diversity and enable the education system, including educators and learners, to minimize, remove and prevent barriers which may exist or arise.

The co-ordinating structures within the departments of education which focus on addressing diversity and overcoming and preventing barriers to learning and development should be constituted in such a way that they bring together the appropriate ministries and departments, professional interests and community resources around the common concern of addressing barriers to learning and development. Teamwork should be supported in providing education support services.

Despite the progress made by the Department of education in the provision of support services within the schools, a lot more needs to be done with regard to certain illnesses which need traditional medicine for treatment

5.4.4 METHODOLOGY, PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

The purpose of chapter four was to discuss the research tools which were used to collect data and to present, analyse and interpret the data.

5.4.4.1 METHODOLOGY

A wide range of literature was reviewed which have some bearing on the topic. The major aim was to establish a broad frame of reference within which the problem of investigation could be identified and defined. The attention was given to the design of the survey. This step involved taking decisions on the samples, sample size and research tools. Then an empirical study was conducted by using the research instruments, namely; observations, interviews and questionnaires techniques.

The questionnaire was sub-divided into two sections in order to obtain the data needed for the purpose of this research study.

SECTION A:

This section required the demographic information about the respondents and included items 1.1 to 1.6.

SECTION B:

This section gathered information regarding traditional medicine in the South African education support services.

- The nature of teachers' perceptions of the need for traditional medicine in schools were covered by items 1.1 to 1.16.

- The nature of learners' problems which require traditional medicine in schools were covered by items 2.1 to 21.16.

- The procedures to be followed in the provision of traditional medicine in schools were covered by items 3.1 to 3.7.

- The guidelines in traditional medicine intervention within a school were covered by items 4.1 to 4.20.

5.4.4.2. PRESENTATION, ANALYSIS AND INTERPRETATION OF DATA

The explanation and description was provided as to the methods employed in the categorisation of responses and the presentation, analyses and interpretation of data. This was followed by an examination of the responses to the questions in the

questionnaire. The hypotheses were tested in order to achieve the results of the study.

5.5 LIMITATIONS OF THE STUDY

The limitations that emanate from this study include the following:

5.5.1 Some teachers, especially those who belong to different denominations that do not believe in the use of traditional medicine, were reluctant to participate in the answering of questionnaires. Hence only those teachers who were willing to complete and return the questionnaire were included in the sample.

5.5.2 Some traditional healers were unwilling to take part in interviews because they believed that it would reveal their healing secrets.

5.5.3 In order to restrict the investigation to manageable proportions, the researcher limited the research study to the teachers of the selected schools, excluding the learners.

5.5.4 This research did not examine the perceptions and responses of parents for the learners of selected schools.

5.5.5 The respondents were all Black teachers. Research on a multicultural sample might have resulted in different findings regarding the use of traditional medicine within the schools.

5.5.6 It was difficult to find those traditional healers who are also educators. As a result very few were interviewed.

5.5.7 The researcher encountered difficulties in interviewing certain traditional healers, because they believed that or even suspected that the information would be used for purposes other than research.

Despite the limitations identified, this research study will provide a much needed basis for future investigation in which a variety of manipulations of independent variables can be used to verify the findings of the research

5.6 RECOMMENDATIONS

On the basis of the aims of this study, the recommendations are formulated, with the view on assisting learners to receive maximum benefits of education support services. The recommendations are:

5.6.1 African researchers must take a closer look at African traditional healing with a view to collaboration between traditional healing and biomedicine which will lead to the appropriate utilization of various health resources. This will result in tremendous progress in the control of African diseases 'ukufa kwabantu' and a better distribution of education support services.

5.6.2 For learners of various cultural groups to receive maximum benefit of education support services, traditional medicine must be used in schools. Learners have different problems which should be satisfied through the provision of all the services within their reach.

5.6.3 Since certain sicknesses need traditional medicine for treatment, there is therefore a great need for traditional medicine in the education support services. All teachers, who identify children who are suffering from 'African diseases' in their respective classes should contact the traditional practitioners, who will then assist the children concerned.

5.6.4 Traditional healers must be encouraged and supported by African researchers to re-establish a relationship of trust and understanding with services providers in education in order to satisfy the learners' needs.

5.6.5 It is of utmost importance for the National Department of Education to examine the policy of control of the use of traditional medicine and health related service in schools. The policy will serve as a guide for the official recognition and acceptance of traditional healers to work hand in hand with other stakeholders in health care.

5.6.6 The establishment of schools as community learning centres for traditional healers must be given high priority. At such centres the following issues *inter alia* must receive attention:

- Traditional healers must be properly trained and their healing services made available in schools; that is, traditional healers' services should form

part of the education support services.

- The training of traditional healers should qualify them as healers as well as health care providers within the school environment; that is, registration with both the Medical Council as well as the South African Traditional Healers' Association.
- Training programmes for traditional healers and modern practitioners should be held on a regular basis by experts, so that the whole training could be synchronized and be more inter-related.

5.6.7 The present study investigated the nature of teachers' perceptions of the need for traditional medicine in schools. It is essential to investigate the nature of parents' perceptions of the use of traditional medicine in education.

5.6.8 Since a relatively small sample size was used in this study, there is a need for further studies to use large samples and standardized research instruments to allow scientific explanations.

5.6.9 A similar study of the nature of teachers' perceptions of the need for traditional medicine in education support services must be extended to other schools with Black, White, Indians and Coloured teachers who teach different cultural groupings of learners, to see if the reported perceptions are similar to this sample. Any similarities in the results would increase the validity of this study's findings.

5.6.10 It is also recommended that a similar study be designed to determine parents' perceptions of the various cultural groups for the Black, White, Indian and Coloured learners who attend same schools, in order to find out whether the reported perceptions are similar to those expressed by this sample. Any similarities in the results would also increase the validity of the findings of this present study.

5.7 CONCLUSION

The major aim of this study was to investigate the prospect and scope for traditional medicine in the South African education support services. In South Africa, there are more than six indigenous groups and four cultural groups. These indigenous groups differ slightly in their cultures as compared to the Coloured, Indian and White people who differ considerably in their cultures. It is for this reason that there is a need for traditional medicine in education support services to cater for the majority of learners. It is believed that this study will be of great value, especially to all the stakeholders who are involved in education, and whose main concern is to satisfy all learners' needs. It is also trusted that the afore-mentioned recommendations will be implemented in order to enhance the satisfaction of the learners' needs.

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APPENDIX A

QUESTIONNAIRE

UHLA LOMBHALAO LWEMIBUZO

QUESTIONNAIRE

PROSPECT AND SCOPE FOR TRADITIONAL MEDICINE IN THE SOUTH AFRICAN EDUCATION SUPPORT SERVICES

STRICTLY CONFIDENTIAL
KUYIMFIHLO

Dr Nembula High School
P O Adams Mission
4100

3 May 1999
☎ 031 - 9038034

Uhlelo Lwemibuzo

Ngibhekene nomsebenzi wokucubungula ngezemfundo eNyuvesi yakwaZulu ngisizana no Professor Sibaya. Lolu cubungulo lwami engilwenzayo luphathelene nokusetshenziswa komuthi womdabu emfundweni njengoba izikole zibhekene nezinkinga eziningi ezinye zazo ezingaxazululwa ngokusebenzisa umuthi wendabuko "Prospect and scope for traditional medicine in the South African Education Support Services".

Njengoba thisha nawe mfundi uthinteka ngqo kwezemfundo ilezi zinkinga ezikhungethe izikole, ngithathe leli thuba ukucela usizo lwakho noma uvo lwakho ngalesi sihlokwana. Imibuzo ebuzwayo iqonde ngqo ngesiZulu (nangesingisi lapho kungecace khona okujongiwe). Ukuyigcwalisa ngeke kuthathe imizuzu engaphezulu kwengamashumi amabili nesihlanu.

> Uvo lwakho oluvezile luyothathwa **njengemfihlo** kanti futhi akudingekile ukuthi uziveze ukuthi ungubani.

Ngiyobonga ubambiswano kokuceliwe.

Ozithobayo

S.R. ZUBANE

Siza uphendule le mibuzo elandelayo ngokunikeza ulwazi esilucela kuwe. Gcwalisa ngokwenza isiphambano (X) esikweleni esifanele.

A. ISIQEPHU SOKUQALA : IMININGWANE NGAWE

1.1 Iminyaka Yobudala

20 - 24	
25 - 29	
30 - 34	
35 - 40	
41 - 45	
45 - 50	
51 +	

1.2 Ulimi olukhulunywa ekhaya .....

1.3 Inkonzo okhonza kuyo (your religious affiliation)

....

1.4 Iziqu/izinga lemfundo onalo kanye nesitifiketi sobuthisha:

.....

.....

1.5 Iminyaka yakho yokufundisa .....

1.6 Khomba ubulili bakho ngesiphambano esikweleni okuyisonasona :

Male	Female

B. **ISIQEPHU SESIBILI : UMUTHI WESINTU**

SIYACELA KUMPHENDULI UKUTHI:

1. Afunde ngokuqaphelisisa isitatimende ngasinye ngaphambi kokunikeza umqondo wakhe.
2. Aqiniseke ukuthi alikho ikhasi aleqayo.
3. Asize athembeke uma enikeza umqondo wakhe.
4. Asize angabonisani nomunye.
5. Asize alibuyise leli phepha lemibuzo.

ISIBONELO

Ngaphambi kokuba uveze imizwa yakho mayelane naleso naleso sitatimende, ake ubheke lesisibonelo esilandelayo:

"Uyakwesekela ukusebenzisana kwezinyanga nodokotela ezibhedlela?"

Strongly Agree Ngiyavuma Impela	**Agree** Ngiyavuma	**I cannot say** Angisho Lutho	**Disagree** Angivumi	**Strongly Disagree** Angivumi Nhlobo
X				

INHLOSO YOKUQALA: Ukubheka ukuthi othisha nabafundi basibuka kanjani isidingo sokusetshenziswa kwemithi yesintu ezikoleni.

	QUESTIONS/STATMENTS IMIBUZO	Ngiyavuma Impela	Ngiyavuma	Angisho Lutho	Angivumi	Angivumi Nhlobo
1.1	Njengothisha uyakwemukela ukusetshenziswa komuthi wesintu esikoleni?					
1.2	Ukusetshenziswa komuthi wesintu esikoleni kudingekile ngoba kwesekeleke enkolweni yamasiko abantu abangama-Afrika					
1.3	Ungameluleka yini omunye uthisha ukuba asebenzise umuthi wesintu uma enenkinga esikoleni?					

	ISEHLAKALO	Ngiyavuma *Impela*	Ngiyavuma	Angisho *Lutho*	Angivumi	Angivumi *Nhlobo*
1.4	Ngiyethemba ukuthi abafundi bangasizakala ezinkingeni abanazo uma besebenzisa umuthi wesintu esikoleni					
1.5	Abafundi kufanele bazizwe bekhululekile ukuxoxa nami njengothisha ngezinkinga ezidinga ukuxazululwa ngokusebenzisa umuthi wesintu.					
1.6	Njengothisha ungameluleka yini umzali ukuba ayise ingane enyangeni uma ubona ukuthi inesifo esidinga umuthi wesintu?					
1.7	Akumele kusetshenziswe umuthi wesintu esikoleni noma ngabe kunenkinga engakanani.					
1.8	Kumele yini ukuba odokotela nezinyanga zibambisane ukuxazulula izinkinga zezifo ezikhungethe izikole?					
1.9	Akufanele neze usetshenziswe umuthi wesintu esikoleni.					
1.10	Akumele ukuba izikole ziqiniswe kumbe zichelwe ngentelezi evimbela imikhokha, otokoloshe, omamtsotsi nomantindane					
1.11	Uyakholelwa yini kumuthi wesintu ukuthi ungenye yezindlela zamasiko ezingasetshenziswa esikoleni ukufeza izidingo zabafundi?					
1.12	Uyakholwa ukuthi othisha bayayisebenzisa imithi yesintu?					
1.13	Uyakholwa ukuthi abanye babafundi bayawusebenzisa umuthi wesintu.					
1.14	Umuthi womdabu kufanele usetshenziswe njengomzamo wokugcina lapho yonke imizamo isihlulekile					

1.15 Bhala inombolo esikweleni eceleni kwaleso naleso sifo ukuze ukhombisa uhla lwezifo ezelapheka ngomuthi womdabu (Rank Order these deseases in terms of the degree they are amenable to treatment by traditional medicine). Bhala izinombolo 1, 2, 3, 4, 5, 6 7 ukukhombisa ukulandelana kwezifo uma zilapheka ngomuthi womdabu.

	ISIFO	RANK ORDER
a.	Isipoliyane	
b.	Isithuthwane	
c.	Umbhulelo	
d.	Amajikantamo	
e.	Ukubona izinto ezingabonwayo	
f.	Ilumbo	
g.	Ukusangana, ukuhlanya noma ukugula ngekhanda	

1.16 Izehlakalo (events) ziyelapheka yini ngemithi yomdabu? Bhala uhla lwezinombolo esikweleni ukukhombisa ukuthi umuthi uyasebenza yini kulokhu okulandelayo. Bhala inombolo kulokho umuthi osebenza kakhulu kukho kanje: 1,2,3,4, njalonjalo.

	ISEHLEKALO	RANK ORDER
a.	Ufuna ukuqashwa esikoleni (appointment)	
b.	Ufuna ukukhushulwa esikoleni (promotion)	
c.	Ufuna ukuthandwa wuthisha omkhulu	
d.	Ufuna ukuxazulula izinkinga zabafundi	
e.	Ukuvala umkhokha omubi esikoleni	

INHLOSO YESIBILI : Ukuhlola izinkinga ezibhekene nalabo bantwana abadinga usizo lokusetshenziswa kwemithi yesintu ezikoleni.

		Ngiyavuma Impela	Ngiyavuma	Angisho Lutho	Angivumi	Angivumi Nhlobo
2.1	Ngokubona kwakho zikhona yini izinkinga zabafundi ezingaxazululwa ngomuthi wesintu? Ungasekela umuzwa wakho uma kunokwenzeka ngokuzibala lezi zinkinga.					
2.2	Ngokwakho uma ingane ihayiza egumbini lokufundela ungeluleka ukuba isiwe enyangeni? *Sekela impendulo yakho.*					
2.3	Akumele ukuba uthisha wezemidlalo avume ukuba kusetshenziswe intelezi ukuze kunqotshwe umdlalo esikoleni.					
2.4	Akumele uthisha axwaye uma ebona ingane isebenzisa umuthi wesintu iziphulula ubuso, izandla kanye nepeni uma izobhala ukuhlolwa (examination)					
2.5	Kumele ukuba othisha abakhulu bavunyelwe ukusebenzisa imithi yesintu ezobenza babe nesithunzi sokwengamela izingane, othisha, abazali kanye neziphathimandla zomnyango wemfundo.					
2.6	Akufanele yini othisha basebenzise umuthi wesintu ukuze bavikeleke emimoyeni emibi ezikoleni?					

		Ngiyavuma Impela	Ngiyavuma	Angisho Lutho	Angivumi	Angivumi Nhlobo
2.7	Ukugqekezwa kwezikole kuthathwe izimpahla kufanele kuvinjelwe ngokusebenzisa umuthi wesintu.					
2.8	Asikho isidingo sokuba kusetshenziswe umuthi wesintu esikoleni ukuze kube khona ukuzwana phakathi kwethu singothisha kanye nothisha omkhulu.					
2.9	Kuyiqiniso elingephikiswe ukuthi ukuze kube khona inqubekela phambile esikoleni kufanele kubekhona ukuzwana phakathi kwabafundi kanye nothisha. Kufanele yini ukuba umuthi wesintu usetshenziswe ukuze lomoya wokuzwana uhlale ukhona?					

* Yikuphi okulaphekayo ngomuthi wesintu kulokhu okulandelayo. Yenza i-rank order (uhla) kanje: 1, 2, 3 njalo njalo.

	ISEHLAKALO	RANK ORDER
2.10	Sivikela ukugqekezwa kwesikole ngentelezi	
2.11	Ukuzwana phakathi kothisha nabafundi	
2.12	Sivikela ukuhlaselwa kothisha yizigcwelegcwele	
2.13	Ukuthathwa kwezimoto esikoleni	
2.14	Ukuthathwa kwamantombazane ngendluzula	
2.15	Ukufaka isithunzi kothisha	
2.16	Ukugqigha ukuze ungadubuleki ngesibhamu	

INHLOSO YOKUTHATHU : Ukubheka indlela engalandelwa uma kuzonikwa imithi yesintu ezohlangabeza izidingo zabafundi

		Ngiyavuma Impela	Ngiyavuma	Angisho Lutho	Angivumi	Angivumi Nhlobo
3.1	Kumele yini ukuba uthisha omkhulu abize abahloli nabazali kuzokwenziwa izinhlelo zokubizwa kwenyanga uma kuhayiza amantombazane na?					
3.2	Njengothisha ungazamukela yini izinhlelo zokuqeqesha izinyanga ukuze kwenziwe imizamo yokuba kuthuthukiswe izindlela ezingasetshenziswa ekusebenziseni umuthi wesintu esikoleni?					
3.3	Akufanele neze ngizikhathaze ngokulalela imibono ezwakalayo ebekwa abafundi mayelane nokusetshenziswa komuthi wesintu esikoleni ngoba lokho akuhlangene nemfundo.					
3.4	Kudingekile njengothisha ukuba ngithole uvo lwabazali maqondana nokusetshenziswa komuthi wesintu esikoleni.					
3.5	Ungaweseka umnyango wezamasiko uma ugqugquzela ukusetshenziswa komuthi wesintu esikoleni ukuze kusizakale abafundi?					
3.6	Kufanele yini ukuba kusetshenziswe umuthi wesintu ezikoleni uma lokho kuzoletha imiphumela emihle ekuhloweni kabafundi?					
3.7	Nginenkolelo yokuthi ukuze kuxazululeke izinkinga eziphathelene namasiko esintu ezikhungethe abafundi ezikoleni, kufanele ukuba umnyango wezamasiko kanye nesigungu sezinyanga seProvince yakwaZulu Natal bakhe izinhlelo zokusetshenziswa komuthi wesintu emfundweni.					

INHLOSO YESINE : **Ukuveza izindlela ezihambelana nokusetshenziwa kwemithi yesintu ezikoleni**

		Ngiyavuma Impela	Ngiyavuma	Angisho Lutho	Angivumi	Angivumi Nhlobo
4.1	Abagqugquzeli bezamasiko emnyangweni wemfundo kufanele babambe iqhaza ekwakhiweni kwemigomo engalandelwa yokusetshenziswa komuthi wesintu esikoleni *ukuze kusizakale abafundi.*					
4.2	Othisha, abazali kanye nabaphathi bemfundo kufanele babambe iqhaza ekwenzeni ukuba abafundi bawuqonde kahle umsebenzi osemqoka wezinyanga ekusebenziseni umuthi wesintu esikoleni ukuze kuxazululeke izinkinga.					
4.3	Izinhlelo zokufundisa kwezinyanga kufanele zakhiwe ezikoleni ukuze izinyanga zibe sesimweni esamukelekile emsebenzini wazo wokusebenzisa umuthi wesintu esikoleni.					
4.4	Kufanele kube khona indawo noma igumbi esikoleni lapho kungasizakala khona abafundi abadinga usizo lomuthi wesintu.					
4.5	Uma kungasetshenziswa okuhle emthini yodokotela kanye nokuhle emthini yezinyanga, ukuyisebenzisa yombili kungaba usizo olukhulu kubafundi kunokusetshenziswa kowodwa kuphela.					

	STATEMENTS	Ngiyavuma Impela	Ngiyavuma	Angisho Lutho	Angivumi	Angivumi Nhlobo
4.6	Ukuncinda kungakwenza ukuhlukumezeka kwengqondo					
4.7	Ukuncinda kungakwenza ukuhlukumezeka komphefumulo					
4.8	Ukuncinda kungakwenza ukuhlukumezeka komzimba					
4.9	Ukugeza ngentelezi kungakwenza ukuhlukumezeka kwenqgondo					
4.10	Ukugeza ngentelezi kungakwenza ukuhlukumezeka komphefumulo					
4.11	Ukugeza ngentelezi kungakwenza ukuhlukumezeka komzimba					
4.12	Ukuphalaza ngomuthi wesintu kungakwenza ukuhlukumezeka kwengqondo					
4.13	Ukuphalaza ngomuthi wesintu kungakwenza ukuhlukumezeka komzimba					
4.14	Ukuchatha ngomuthi wesintu kungakwenza ukuhlukumezeka kwengqondo					
4.15	Ukuchatha ngomuthi wesintu kungakwenza ukuhlukumezeka komphefumulo					

	STATEMENTS	Ngiyavuma Impela	Ngiyavuma	Angisho Lutho	Angivumi	Angivumi Nhlobo
4.16	Ukuchatha ngomuthi wesintu kungakwenza ukuhlukumezeka komzimba					
4.17	Ukuncinda kuyazelapha izinkinga zokufunda esikoleni					
4.18	Ukugeza ngentelezi kuyazelapha izinkinga zokufunda esikoleni					
4.19	Ukuphalaza kuyazelapha izinkinga zokufunda esikoleni					
4.20	Ukuchatha kuyazelapha izinkinga zokufunda esikoleni					

APPENDIX B

LETTER SEEKING PERMISSION FROM KWAZULU NATAL DEPARTMENT OF EDUCATION AND CULTURE

Dr Nembula High School
P.O. ADAMS MISSION
4100
27 September 2000

The Superintendent General
KwaZulu Natal Department of Education and Culture
Private Bag X04
ULUNDI
3838

Dear Sir

REQUEST FOR PERMISSION TO CONDUCT RESERCH WITH TEACHERS AS SUBJECTS

I, the undersigned, hereby request your permission to do a research project with the aim of examining "Prospect and scope for traditional medicine in the South African Education Support Services". This research study is towards the degree of M. Ed., and is being carried out under the supervision of Professor P.T. Sibaya at the University of Zululand.

There are strange events which cause interest in exploring the relationship between traditional medicine and western medicine within the school situation. This indicates the need for research to be conducted on teachers' perceptions of traditional medicine use in the education support services. This research study is intended to meticulously identify the need for traditional medicine in education to provide pupils' needs, and the most efficient way to follow.

The study attempts to provide suitable answers to the following questions:

1. What is the nature of teachers' perceptions of the prospect and scope of traditional medicine in the school situation?
2. Which type of illnesses, teachers believe that require traditional medicine practices treatment procedures within the school?
3. What is the modus operandi that can be followed to effect traditional healing/treatment within a school?
4. Which guidelines will teachers recommend for implementation of traditional healing procedures within the school?

I have enclosed a questionnaire to be completed by teachers which will be handed out to the selected schools.

I thank you for taking this matter in your consideration.

Yours sincerely

Sibusiso Rolland Zubane

APPENDIX C

LETTER ASKING PERMISSION FROM THE SUPERINTENDENTS OF *EDUCATION MANAGEMENT*

Dr Nembula High School
P.O. ADAMS MISSION
4100
12 October 2000

The Chief Superintendent
_____
_____
_____
_____

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT RESEARCDH AT SELECTED SCHOOLS IN YOUR DISTRICT.

I am currently conducting research on the "Prospect and scope for traditional medicine in the South African Education Support Services" as part of a Master Degree in Education. This research is being carried out under the Supervision of Professor P.T. Sibaya at the University of Zululand (Department of Educational Psychology).

My I request you to grant me permission to distribute questionnaires for completion by educators of the following selected schools in your district:

1. 4.

2. 5.

3. 6.

The questionnaire should not take more than twenty minutes to complete in order to ascertain this research does not interfere with the normal functioning of the schools. The information will be kept confidential and will serve no other purpose either than that pursued by this study.

Your contribution to the success of this research study is highly essential, because the findings of the investigation will enable the researcher to make worthwhile recommendations with regard to the provision of traditional medicine in the South African school support services.

In anticipation, thank you for your kind assistance.

Yours faithfully

Sibusiso Rolland Zubane

APPENDIX D

RESPONSES FROM THE SUPERINTENDENTS OF EDUCATION MANAGEMENT

KWAZULU-NATAL DEPARTMENT OF EDUCATION AND CULTURE

DURBAN SOUTH REGION

UMBUMBULU DISTRICT

Tel: (031) 9150036; 9150001; 9150222; 9150221
Fax. (031) 9150189

Private Bag X1022
UMBUMBULU
4105
18 October 2000

The School Governing Bodies

RE: PERMISSION TO CONDUCT RESEARCH

1. This is to certify that Mr S.R. Zubane has been granted permission by this office to conduct research in schools of his choice.

2. The research is designed for the M. Ed. Degree, and it should be conducted in the form of written questionnaire.

3. Since the research to be conducted is for educational purposes, I kindly request you to offer Mr Zubane the necessary assistance.

Yours faithfully

T.P. MZOBE
DISTRICT MANAGER (ACTING)

KWAZULU-NATAL DEPARTMENT OF EDUCATION AND CULTURE

NORTH DURBAN REGION

NDWEDWE DISTRICT

Tel: (032) 5331015

Private Bag X532
NDWEDWE
4342

20 October 2000

Mr S.R. Zubane
Dr Nembula High School
P.O. ADAMS MISSION
4100

Dear Sir

ACKNOWLEDGEMENT OF RECEIPT OF YOUR LETTER FOR PERMISSION TO CONDUCT RESEARCH.

I, the undersigned, hereby acknowledge receipt of your letter dated 12 October 2000 in which you ask for permission in order to undertake research in our district.

I appreciate your interest for selecting our schools with the intention of conducting research. You are permitted to conduct research in any of our schools. I would like to assure you that our educators will give you their co-operation in this matter.

I wish you good luck with your research.

Yours sincerely

FOR CHIEF SUPERINTENDENT