TRADITIONAL HEALING AT UMLAZI TOWNSHIP AS PART OF INFORMAL BUSINESS

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This dissertation is dedicated to my parents.

"NINA ENAVELA ENYANDENI"

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ABSTRACT

The aim of this study was to investigate how traditional healers operate at Umlazi township with special reference to their socio-economic status, systems of working and their problems and future plans. The study showed that there were more male healers than female healers at Umlazi. The ages of healers ranged between twenty and sixty-nine. All the healers had dependants, although their numbers varied. Most of the traditional healers at Umlazi did not have family members. The majority of healers lived at Umlazi township. Most of the healers worked at Umlazi-Glebe and kwaMnyandu Station and some used public transport to their places of work such as buses, taxis and trains. There were those who walked to their places of business. The costs of transport were low, between R50 and R79 per month. The healers could not tell with precision what their monthly incomes were, they did not keep records of income and expenditure. Most of the healers had only primary education and their training was informal. Most of the healers were once employed in formal industries. Working hours, working days and payment for services differed greatly. The healers provided more

services than the formal healing system. Their main problem was absconding. Some healers are in favour of being incorporated into formal healing system.

CHAPTER 1

1.1 INTRODUCTION

The informal sector is an important component of the Third World economics which are a result of a very high level of urbanization. The emergence of the informal sector in the Third World countries resulted from the inability of the masses to be engaged in full production employment. As Bernstein (1977) referred to the informal sector as composed of wage-labourers-in-waiting, most of the people who depend on this sector do not have enough money to feature in the formal sector.

Geographers have paid more attention on the informal sector in most of their work. These geographers have been concentrating on parts of informal sector such as shebeens, street hawkers, petty traders, taxis, shoe-making, building contractors etc. Rogerson C.M. has written ***The South African Economy After Apartheid.*** In this paper he concentrated on aspects such as development of urban informal sector. Contributions on this emanated from several researchers into the dynamics of specific branches of small scale production and distribution. Mathur and Moser (1984) have written on urban informal sector. Beavon and Rogerson (1986) have written an

article on ***Temporary Trading for Temporary People***, the making of hawking in Soweto. This paper was presented to the International Geographical Union. Another article by Beavon and Rogerson in 1986 was ***The Council versus the Common People*** which was the case street study in Johannesburg related to informal trading. This included an account of the Council versus the Indian Flower Seller. Besides these productive writers, there are many others who presented work on informal sector in South Africa. These writers, however, neglect traditional healing as part of informal sector. Dr Tony Cumming from the Institute of Natural Resources, University of Natal, Pietermaritzburg has written on Herbal Medicine as a hidden economy. Nevertheless, the scarcity of work regarding informal healing leaves much work for geographers especially in South Africa.

The relationship between traditional healing and informal sector has been established by many factors.. Firstly the rural migrants who arrive in the cities have no alternative except to find jobs in order to survive in the cities since one of the pull factors behind their movement to cities is employment opportunities. When some of those migrants fail to find jobs, they resort to their knowledge of healing. This in turn helps to provide primary health care for the people.

Secondly, there is a relationship between geography, traditional healing and informal sector because the healing activity has to do with primary health care of the population. Population is one of the main concerns of geographers and they tend to look at the influences of medicine on it in terms of fertility and mortality. In traditional healing systems some people survive and some die as the case is with formal, modern medicine. The result of this has an effect on population growth or decline.

The surviving population need to be employed so as to be able to meet their demands of food, shelter, clothing and health care. Out of this population some members may not afford formal medicine and they depend on traditional healers for their health care. Dauskardt (Wits 1990) held that there has not been sufficient investigation in traditional healing in South Africa. According to him this field of activity should be explored. Dauskardt said that traditional medical systems remained an active and important source of health care provision in developing countries.

There is a need for government policies and supportive legislation to promote the linking of traditional medicine to national health coverage. For Dauskardt the

lack of established contact between traditional medical practitioners and health planners as well as the cultural distance and prestige of competition between trained medical personnel and African healers, were obstacles to integrated health care.

In Natal traditional medicine was legalised through the Natal Code of Native Law, which provided for the licensing of some of the traditional medical practitioners (Dauskardt 1990).

1.2 CHAPTER SEQUENCE

As chapter one of this study paid more attention on the need for more focus on traditional healing as part of the informatl business, Chapter two provides a conceptual framework with regard to the informal sector and traditional healing. Chapter three gives the methodology used in the study, the hypothesis that is advanced, the historical background and the geographical situation of the study area, sampling as well as data collection.

Chapter four deals with the analysis of the findings of this study and especially with regard to the socio-economic status of healers under level of education, working days and hours, transport costs, monthly income,

type of training undergond etc. It also looks into the question of services offered by the healers.

Chapter five gives the evaluation recommendations and conclusion of the study.

CHAPTER 2

LITERATURE SURVEY

2.1 INTRODUCTION

It is very difficult to define employment in the less developed countries particularly where Agriculture is the main economic activity. Under-utilisation of labour manifests itself in different forms namely (i) open unemployment (ii) under-employment and (iii) the visibly under-utilised (Todaro 1977). Unemployment and under-employment in the less developed countries particularly in Africa are most serious. It is estimated that about thirty percent of the total labour force in third world countries are under-utilised as a result of unemployment. This serious problem is made worse by the rapid population growth (Todaro 1977:75)

The increased rural population densities, lagging rural agricultural production, the effect of education, the income inequalities between rural and urban areas etc have all contributed to increased migration to urban areas and rapid urbanisation in the Third World countries.

The rapid urbanisation in the Third World countries result to serious problems of urban unemployment, lowered wage rates in urban areas, serious overcrowding and consequent growth of informal settlements mainly characterised by informal means of making a living. Among these informal activities in the less developed countries is traditional healing.

2.2 THE THIRD WORLD URBANISATION

A common and wellknown problem of the developing countries is the narrowness of the home market. The phenomenon is due, not only to the generally low income level and unfavourable distribution of incomes but also the distorted dualistic economy (Nyilas 1977). Both outwardly oriented capitalists and especially precapitalist sector set, by their nature, according to the Nyilas, limit the development of internal commodity relations.

Conditions of poverty in the Third World are largely the result of the combined operation of monopolistic structures and the state. The state aggravates this through its economic and fiscal policy. The present pattern of economic growth is responsible for an increasingly unequal income distribution and hinders both

employment expansion and development of the domestic market for modern products. One of the principal results of this is the existence of the informal sector of the urban economy. The main distortion created by the monopolistic structures affect the type of goods produced. (Santos 1979).

Dynamic industry produces for exports and the rich rather than the less favoured domestic classes (Barros de Castro 1971, Volume II). The proportion of national resources invested in goods and services destined for upper classes consumption is at least three or four times higher in some countries e.g. in Chile it is four times higher than in Great Britain (Kaldoe 1965).

The development of this trend means greater capital accumulation, reduction in the prosperity to consume of the masses and increasing monopolisation of the national income by a priviliged few. A vicious cycle is established, as income continues to concentrate, the consumption of high income groups increasingly diversifies and the expansion of demand becomes even more socially inadequate, resulting in the under-utilisation of factors of production. The poor are doubly disadvantaged for they only have access to the products that entrepeneurs find profitable to produce whilst the

production of consumption goods decrease. This places a ceiling on employment and makes available only a restricted choice of collaborators in the modernization process (Santos 1979).

Income inequalities are maintained by a structure of production that oriented towards these sectors of the economy which are most susceptible to technological modernization and consequently the most profitable. Since the capitalist sector is not in a position to transfer sufficient capital to the domestic sector, persons engaged in this sector suffer a cumulative decrease in income (Watters 1967).

The adoption of an imported growth model has other consequences for the level of employment. Each new activity established in an under-developed country facilitates the creation abroad of a significant number of jobs. Factory construction, raw material supplies, commercial services, transports and educational and research activities benefit directly. A recent survey conducted by the Harvard Business School suggests that 600 000 American jobs directly depend on the foreign activities of American based multinational corporations (Rattner 1972).

Dasgupta (1964) believes that the low wages paid in the domestic sector of the economy have no effect on modern-sector wages. He suggests that wages always tend to rise rapidly in the capitalist sector, even where labour is in abundant supply.

In most less developed countries, the prices of capital and labour are not left unaffected by technical progress. There are many unskilled jobs in the formal sector, for which labour from the informal sector can be recruited, the price of which is in fixed proportion to the modern sector wages though they are determined by supply and demand factors in the informal sector. Since demand for this type of employment continuously increases, there is a tendency for wage levels to fall (Frankenhoff 1971). The potential advantages accruing to wage-earners (in capital intensive activities are not realised (Santos 1979).

Theoretically, reductions in the costs of production obtained through the introduction of advanced techniques should result in lower prices, higher profits and an increase in the number of wage earners (Sylos Labini 1969). In reality, for prices to decrease, an as yet unheard of degree of agreement among producers would have to be established. Thus profits continue to rise while

wages increase only in certain branches and for certain categories of workers (Santos 1977).

In technology intensive activities, highly skilled workers are paid relatively high wages. These workers are not easily substituted and this may give them considerable bargaining powers. Among unskilled workers wages often vary according to the branch of activity. Nevertheless, wages of skilled workers may be twice those of unskilled workers (Santos 1979). In South Korean city of Taegu industrial development has seen the increase in the number of skilled workers faster than that of unskilled workers, the latter being progressively replaced by machines. The majority of workers with relatively high wages consequently tend to increase, while conditions impending the integration of the majority of workers are generated (Lee, M.S., 1971).

Economic growth is thus oligarchic and inegalitarian. The improvement experienced by some is not socially significant, for the per capita income of active persons increases only in the upper income groups. Thus employees in strategic sectors gain preferential access to a larger part of the value of capitalist production in exchange for their poor entrenchment in a consumption oriented society (Rands 1970).

Under these conditions, a limited expansion of the middle classes and their prosperity to consume can be seen as a manifestation of the strength and assertiveness of the modern capitalist sector (Niemeyer Pinherd 1971). However, expansion has decelerated recently. Upward social mobility, is selective and discriminatory, putting a more acute pressure on the wage levels of the lower classes (Sunkel 1970). Growth of the middle class does not make income distribution more equal, but on the contrary makes income distribution more unequal (McGee 1971).

Generalised commodity production established initially through the extension of commodity production and its social relations exists where individuals are unable to exist and to produce themselves outside of circuits of commonity, economy and divisions of labour generated by the capital wage labour relation and its contradictions (Bernstein 1986). Many people in various indigenous societies of the Third World attempted to resist incorporation in both its political and economic dimensions, the former manifested through colonial conquest, the latter through pressures to participate in new types of production and division of labour that were destructive of their previous ways of life (Bernstein 1977).

No agricultural and particularly urban petty commodity, production in Third World economies displays an enormous amount of variation in its activities and forms of integration as the following is suggested by Johnson and Bernstein pp.260-261).

> "The informal sector or urban petty commodity production comprises the provision of personal and other small scale trading and hawking, the preparation of food for sale in the home or on the streets, prostitution, the scavenging of garbage for recycling and resale".

Third World economies are characterised by generalised commodity, production no less than those of the first World. At the same time the concept of differential commoditization or intensity of commodity production recognizes that there are different types and degrees of development written capitalism which have some correspondence with different forms of integration in the market economy (Bernstein 1977).

2.3 NON-EMPLOYMENT, UNDER-EMPLOYMENT, POVERTY, AND TERTIARISATION

The modernization of the economy is accompanied by a

Technological rigidity which, by severely limiting the scope of input-substantiability, inevitably inhibits the growth of the formal sector employment. The most efficient techniques for industrial expansion seem to have been conceived as if labour were a scarce commodity (Eckaus 1955). Such a formulation is inappropriate even in the context of developed countries, and completely untenable in respect of the underdeveloped countries, modernization of this sort produces industrial growth accompanied by increased employment problems such that the creation of jobs lead to the increase in non-employment (Singer 1970).

Under monopolistic or obligopolistic market conditions the successful absorption of surplus labour is at its most difficult. The problem of non-employment is dynamic and not static, since monopolistic organisation has such a limited ability to provide jobs and thus drive prospective workers into other sectors of the economy which are, for the most part, unable to offer either regular wages or permanent employment. The technical factors are also important. Larger firms especially the multinational corporations, are not interested in using labour intensive techniques because the larger the labour force thus constituted would represent a political threat (Santos 1979).

The source of the problem lies in the slow growth of the modern sector relative to population increases in the traditional sector, thus employment opportunities do not expand, per capita income remains low and may even decrease. In reality, however, there are no two employment problems in the Third World (Meyer 1964). On the contrary the labour market is unified though it is characterised by an extremely differentiated structure (Quinjano 1974).

What is known as relative surplus population is created at certain points by the trend in accumulation in each of the spheres of capitalist production. This idea goes back to Marx, for whom the relative surplus population was made up of labour-power rendered superfluous in the very process of capital accumulation itself (Durroux 1970).

The creation of indirect employment largely depends on the technological level of the new industry in question. The wider is the gap between the industry and its new economic and social environment, the more the concomitant employment ignores the very regions that would most benefit. It is the large cities of the host country or the countries exporting the technology which benefit. As the host country industrialises, urbanization becomes

more and more tertiary in character (Santos 1979).

Poverty is even consistent with growth, if the growth is of recent origin. Currently poverty is worsening everywhere, in underdeveloped countries recently having embarked on the path to material progress as well as in those which began the process at an earlier date. The reason for this poverty is that technological modernization produces growing social and economic disparities. In the name of progress, a large part of the nations' resources is allowed to those who are already rich (E.A. Johnson 1970).

The poor carry the heaviest burden of the Third World modernization because the unemployed and other groups at the bottom of the wage scale, bear proportionally more than others the social cost of various development projects (Rattner 1964). Such an industrial reserve army is a general condition of capitalist production (Durroux 1970).

Impoverishment is universal but in the rural areas it takes on the most flagrant forms of social inequality. Amsdem (1971) in analysing the case of Kenya, showed that the relative impoverishment of urban wages had taken place partly to the detriment of earnings of rural areas.

This phenomenon continues to characterise the under-developed countries and so caused, to the same extent, by the inability of the small farmer to pay the price of even relatively inexpensive technological improvements (Ardant 1963).

In Mexico, for example, an industrial worker in 1950 earned 393% more than an agricultural worker. Ten years later, the farmer's wages were 454% that of his rural counterpart. This situation has only changed in areas influenced by Third World economic metropolis where the countryside has been penetrated by industrial forms of production. The rural-urban difference in wage levels exacerbates the exodus from the country to the cities and towns, to the extent that one can justifiably speak of a transfer of poverty from rural areas to urban areas.

The time has long passed when Moselitz's question concerning Asian, urbanization (1957:48) might still legitimately be asked; the expansion of Third World cities can no longer go hand in hand with the massive abolition of poverty (Hoselitz 1957). Morelitz believed that in the long run, the process of industrialization would be accompanied by income redistribution in the cities as well as in the rural areas. However, under the present conditions, urbanization facilities aggravates

inequalities, as (Rattner 1971) points out that economic and spatial concentration is correlated with the parallel phenomenon of cumulative poverty within economic growth centres themselves. It has been observes that in preceeding periods, the assimilation of migrants into urban activities took place relatively quicker, as did that of established urban residents (Munoz Garcia et al. 1971).

The proliferation of Third World shanty towns coincide with the growth of urban poverty and the acceptance of imported consumption models. Money is scarce and various consumption needs must therefore compete, new tastes are acquired through intensive advertising campaigns, and are satisfied by the expenditure on food (Frankman 1970).

At Porto Alegre, in Brazil, for example, the percentage of shanty town residents has increased rapidly in recent years (1 per cent in 1940; 5 percent in 1950; 13 percent in 1960). Even in Sao Paulo, the economic metropolis of the country *"The Favela"* population has increased from 2% to 4% in 1966 to 20% in 1974 (Valenzuela 1970; Shaefer 1976). In Manilla, the squatter population has increased from 360 000 in 1962 to 767 000 in 1968. This tendency coincides with economic growth. Taiwan, a fast growing economy, according to the conventional defination, can

boast that one third of its population live in hovels (Simon 1971).

It is not enough merely to construct accommodation with rents which are theoretically within the reach of the lowest wage-earners or day labourers. Often people will abandon new housing to return to the shanty town closer to their places of employment, as recently happened in Dio (Valadares 1972).

The South African sociologists use the term ***"Marginal"*** to describe the disinherited masses, the victims of the evolution of capitalist production. Their aim was to juxtapose the problem of poverty with the so-called modernity. Thus the theory of marginality was elaborated (Quitano 1974); Cardoso 1971; Nun 1969; Cardona 1968), yet it is a relatively old term to define a new situation. Park (1928) was one of the first to use the term marginal to refer to cultural hybrids, to those living on the margin of two cultures and two societies. Cuber (1940) also spoke of those occupying a peripheral position between two unrelated cultural structures, complexes or units.

There is wonder whether the urban poor recognise themselves as marginal (Joan Nelson 1969). This

population is not surplus in rural areas and is not superfluous from the economic viewpoing (Bettelheim 1950); Niemeyer Pinheiro 1971). There has been a distortion of the development process through technological modernization which has prevented the economic participation of that part of the population which McGee (1972) calls the *'Proto-Proletariat'*. Gunder (1968) says that these poor are not socially marginal but rejected, not economically marginal but exploited and not politically repressed.

2.4 THE NATURE OF THE INFORMAL SECTOR

The informal sector is highly differentiated from the formal sector with respect to its activities, resources that household and individuals can mobilise to pursue them and the incomes they derive from them. The large number of people struggling to gain their living through urban petty commodity production has the effect of intensifying competition between them, subjecting their control by a hierachy of middlemen. This increases precariousness of the ventures they engage in and decreases their incomes and standards of living (Johnson and Bernstein 1977, pp.260-261).

In the informal sector the conditions of work, pay and

social insurance are not observed and the workers do not have opportunity to organise themselves into trade unions. There is casual and irregular wage work, employment in personal services or in small scale enterprises in manufacturing and services. In Latin America the term marginalization has been used to refer to the effects of modern capitalists industrialization which, it is argued, provides fewer and fewer jobs relative to the numbers of those seeking them. Those unable to find regular wage employment, the marginals, consequently swell the ranks of the informal sector, forming and increasing proportion of urban population (Johnston and Bernstein 1982, p.93).

Informal activities are not confined to employment on the periphery of the main town, to particular occupations or even the economic activities. Rather, informal activities are the ways of doing things characterised by:

(i) Ease of Entry.

(ii) Reliance on indigenuous resources.

(iii) Family ownership of enterprises.

(iv) Small scale operation.

(v) Labour intensive and adapted technology.

(vi) Skills acquired outside the formal school system.

(vii) Unregulated and competitive markets.

Santos (1979) gives other characteristics of the informal sector as follows:

(i) It is generally family organised.

(ii) Capital is scarce.

(iii) Hours of work are irregular.

(iv) Prices are negotiable between the buyer and the seller.

(v) Credit is personal and non-institutional.

(vi) There is direct and personal relations with clients.

(vii) Technology is labour intensive.

The informal sector appears to offer a panacea of urban unemployment problem, while at the same time providing scope for the eclosion of local entrepreneurial talent. The size of the informatl sector is impressive enough. Admittedly, attempts to asses its share of the urban labour force encounter serious difficulties. Not only is the informatl sector nearly impossible to delineate, but many of its workers have reason to evade attempts to record them. Nevertheless, there can be no doubt that in

most Third World countries a large proportion of the urban population forming the work force is found in this sector. Estimates for cities in six Latin American and two Asian countries suggest that between 39% and 69% of the urban work force is found in the informal sector (Souza and Torman 1976).

The view that the informal sector provides the answer to urban unemployment problem is strengthened by the notion that the government policy towards it contains few elements of positive support and promotion, and many elements of restriction and harrassment as the *International Labour Organization (1972)* mission argued in the case of Kenya. It should be noted, though, that Kenya gained independence only in 1963 and that its European settlers had established regulations expressly keeping African enterprise out of the cities (Guger 1981).

Throughout the informal sector many of those conventionally described as self-employed are thus in fact disguised wage workers such as outworkers or commission sellers or dependent workers who depend on one or more larger enterprise for credit, the rental of premises or equipment, a monopolistic supply of raw

materials or merchandise or monopolistic or oligopolistic outlet for their production (Bromley and Gerry 1979).

Any assessment of the prospects for the informal sector and of policy options, has to be both specific and comprehensive i.e. has to focus on particular activities and those engaged in them and to take full account of linkages with the formal sector in particular. Beyond that, any attempt to alleviate the problem of urban surplus labour is confronted with the prospect that its very success will attract additional migrants from the rural areas. The urban unemployment problem cannot be solved within the urban area unless it is sealed off by a break in the rural urban connection (Gugler 1981).

Entry in the informal sector is relatively easy since it is labour and not capital intensive i.e. labour is the key factor. Since labour is cheap, it is not difficult to start up a business; a sufficient number of employees can easily be found because the news of job opportunities travel very quickly (Santos 1979).

The informal sector entrepeneur does not necessarily need an education and business is often done without proper papers. Illiterates sometimes have less trouble in finding a job than those having some education (Tagri

1971). In an Indian sample, though 50% of unemployed illiterates had not worked for at least one year, 75% of those with primary school education were in the same situation. Often illiterates or semi-illiterates earn more than those who have completed some form of education (Canrvoy and Katz; Munoz Garcia et al. 1971).

It has been observed that new arrivals in the city almost always find employment quickly as it is shown in the following example of Brazil illustrating the waiting period between migration to the city and first employment. It is clear that the majority of new arrivals in Brazil get employment earlier than the already settled migrants. In Sao Paula 84.3% of males and 75.8% of females with less than one month in the city were able to find employment. In Americana 87.1% of males and 71.2% of females with only one month in the city could find employment (Hutchinson 1963).

In a simplified manner, the informatl sector activities can be characterised by three types of entry requirements. There are activities which require neither capital nor skills, activities requiring small quantities of personal or borrowed capital and finally those requiring both skills and capital. The second type includes domestic activities, the first commercial as

well as other tertiary activities and the third group consists essentially of artisans (Santos 1979).

The informal sector activities present some important contrasts with agricultural petty commodity production. The first is that urban economy presents much less opportunity for sources of subsistence income, compared with farming or animal husbandry. Accordingly, with urban petty commodity, production is generally more intense in the sense of the flow of commodities in both conditions that it typically entails. A second point of contrast is provided by what is termed free entry activities in the urban informal sector which means ways of trying to gain a livelihood that requires little investment of resources or technical skills. Such activities include small scale hawking and trading, selling newspapers or cigarettes on street, washing cars or clothes, other kinds of cleaning work, porterage around market places, the scavenging and recycling of garbage, prostitution and so on. These free entry activities provide a minimal means of survival for large numbers of people in most Third World cities. These are often pursued by recent migrants to the city and others who are unemployed in order to get by while they look for regular wage work. If one sort of activity is going badly, they can try to switch to another without losing

precious resources in the process (Bernstein 1977).

At the same time, the mobilization of resources for people in great poverty involves costs that contradict what an outsider may consider *"Freedom"* of entry into a particular sector of activity. The story of an unsuccessful attempt by an urban marginal in Cali, Colombia to establish himself an independent scrap merchant which involved selling almost all his household meagre possessions to raise some working capital has an epic quality of struggle reminiscent of the struggle of many poor peasants to cling on to a piece of land (Ruisque-Alcaine and Bromley 1979).

The central importance of land as means of production in agriculture, the value associated with land in peasant cultures and the attachment of peasants to their land, are all very different from the intense spatial and occupational mobility of urban free entry activity (Bernstein 1977).

Not all small scale commodity production of course, manifest this intense flux. Small scale engineering and metal working carpentry, building, shoemaking and tailoring or the repair and servicing of machinery require relatively high levels of resources, special

premises and stocks of tools and materials as well as specialised skills. It is from activities of this kind that a minority of petty commodity producers might accumulate capital to the extent that they can themselves become small capitalists, expanding their scale of production through employing the labour of others in the same way as the rich peasant capitalist farmers of the Green Revolution (Bernstein 1973).

Harts (1973) argued that the informal sector provided a wide range of low cost, labour intensive competitive goods and services and recommended the promotion of this sector (Gugler 1981).

2.5 THE RELATIONSHIP BETWEEN FORMAL AND INFORMAL SECTOR

The difference between the formal and informal sector is one reason for the emergence of a critique of large-scale industry similar to the populist critique of large scale agriculture. Perhaps the best known is that of Schumacher (1973). In his book *"Small is Beautiful"*, he represents a critique together with a plea for a new kind of labour intensive, small scale industry that he calls *Intermediate Technology*. Schumacher not only argues in favour of a technology that uses labour but one that produces better work. He writes in favour of a wide

ranging craft approach to work and against fragmentation of work that produces alienation (Weld 1988).

The so called informal sector enterprised often grow in the interstices of formal sector enterprises whether in rural or rapidly growing urban areas of the Third World. Sometimes they have been made to grow at least to survive through massive state assistance (Schmitz 1982). Dualistic conceptions of the Third World economies have long been current. An early distinction was between the modern industry and traditional artisans, but the unsatisfactory nature of these levels become obvious. Modern activities such as servicing and repairing imported automobiles or television sets, are frequently carried out in a quite traditional manner i.e. in small, poorly equipped shops (Gugler 1981).

In the 1960s, renewed attention was drawn to the *"Murky"* sector because in country after country substantial additions to the urban labour force failed to show up in employment statistics. While there was also an increasing recognition that a large and growing number of people were engaged in enumerated activities, they were thought to be working in the service sector. However, statistical enumeration is primarily a function of size of firm's workforce, and small enterprises in the primary

sector e.g. peri-urban gardening and in the secondary sector shoemaking for example, are just likely to go unenumerated as are street vendors (Gugler 1981).

The new terminology which distinguishes informal and formal sector was presented by Harts (1973). On basis of research in a low income neighbourhood in Accra, Ghana , he emphasized the great variety of both legitimate and illegitimate income opportunities available to the urban poor. McGee (1976) explored various approaches towards what he called *'Protoproletariat'*. The response to Hart's plea that a historical, crossucultural comparison of urban economy in the development process must grant a place into the analysis of informal sector as well as formal structures was nothing less than overwhelming (Bernstein 1977).

The interrelation of the formal and informal sectors is strikingly illustrated in Birbeck's (1979)* account of garbage pickers in Cali, Colombia. The largest proportion of potentially saleable garbage is collected and started on its way by garbage pickers working on their own and most of their production is destined for large factories. In the paper industry waste paper provides a third raw material requirements and some 60% of that waste paper came from individual pickers. The

earnings of the majority of pickers are about a third of the lowest wage paid by the major paper company, and they are neither assured of a fixed and regular income nor enjoy employee and social security benefits (Gugler 1981).

Quijano (1974) moves beyond the two sector distinction and explores the articulations in a three sector model for Latin America. Monopolistic formations dominate the manufacturing sector, they are oriented towards complex technology imported from industrialised countries and tend to exclude labour. An intermediate level of competitive manufacturing and artisan production has neither the stability, nor the capacity of expansion necessary to admit in a stable way the labour force that assembles around it or to retain that which it already has. Finally, a marginal pole lacks stable access to basic resources of production that serve the dominant levels of each economic sector, under such conditions the occupations and mechanisms for their organization can operate only around residual resources and for the most part residual activities (Bernstein 1977).

In posing questions of the possible implications of recession for South Africa's informal economy, it is necessary to understand clearly the relationships between

the formal and informal sectors. Following the definitions used in the recent series of innovative studies led by Al Jandro Portes and Benton 1984, Portes 1985; Portes and Johns 1986; Portes and Sassen-Koob 1987) the concept informal sector will refer broadly to the sum total of income earning activities with the exclusion of those that involve contractual and legally regulated employment (Portes and Sassen-Koob 1987). It is contended that while this definition encompases criminal activities, the term is customarily illegal but in which the production and exchange escape legal regulations (Portes and Sassen-Koob 1987).

At the outset, it must be appreciated that the division between the formal and informal sector is entirely artificial. The growth and complexion of the informal sector does not occur as a form of development which is in some way divorced from that of the formal sector. Indeed, it has been suggested that the size and composition of the informal sector is the consequence of the simultaneous functioning of two different economic processes (Gilbert 1986; Portes and Sassen-Koob 1987).

In the sphere of production, it has been shown through several studies in the developing world that many sectors of formal industry sub-contract the more labour-intensive

parts of production to informal or backyard manufacturers (Gerry 1979, Peattie 1983; Portes, Blitzer and Curtis 1986). Underpinning this pattern of informalization in manufacturing has been the juxtaposition of an extensive labour legislation, frequently copied from that of the advanced countries, and abundant labour supply (Portes and Sassen-Koob 1987). Together these two factors have meant that formal sector manufacturing enterprises have both the inventive and the facility to by-pass the regulators constraints on the use of labour (Portes and Benton 1984; Portes and Johns 1986). Throughout the developing world there is generalised resistance among modern sector employees to increasing a contractually hired labour force that raises costs and decreases managerial flexibility, and there is a concomitant tendency to make use of highly elastic supply offered by informal sector workers (Portes 1986).

2.6 INFORMAL SECTOR AS REFUGE FROM DESTITUTION

The conventional wisdom in much of the writings on the informal sector is that it functions as a refuge from poverty, an alternative to destitution for those deprived of access to formal sector employment (Moser 1984). In other words the burgeoning of an informal sector, especially in the rapidly growing cities of the

developing countries is viewed as inseparable from the fact that the informal sector is not growing at a sufficient pace to furnish an adequate volume of work opportunities. Accordingly those persons unable to secure a foothold in the formal sector activities as means of survival (Portes and Benton 1984; Portes and Sassen-Koob 1987).

Within South Africa's Black townships and rural Bantustans much of the current rapid expansion of an informal sector is inseparable from the arrested development or even demise of the formal sector which is simply not expanding at a sufficient pace to absorb potential job seekers (Sarakinsky and Keenan 1986). Given the rise of the unemployed and under-employed populace in a situation where there exists little or no social welfare support inevitably, the poor are drawn to eke out a survival existence in one of a range of precarious or low income marginal informal niches (Rogerson and Beavon 1980; Maadorp 1983; Krige 1985; Natrass 1987).

Many of these marginal survival income niches, including begging, petty theft, prostitution, garbage-picking or beer-brewing clearly would fall outside the range of those more socially acceptable informal sector activities

which the South African state is currently trying to stimulate (Rogerson 1987). Nonetheless, the continued precipitate decline in the formal economy, with major retrenchments in manufacturing, constitution and many spheres of service activity compels many of the poor to seek out ways of weathering a recessionary climate even through such socially less acceptable informal sector income activities (Booth 1986, 1987; De Kock 1986, 1987).

2.6.1 DOMESTIC ACTIVITIES

Domestic wage labour constitutes one of the most important types of services and provides much employment. More than other services, it absorbs large numbers of migrants. A survey undertaken in Calcutta showed that domestic activities constituted a single most important and common initial occupation in the sample whilst the other occupations mentioned were trade, some other services and crafts. Also in Calcutta, the small shop-owners made up 11,8% of established city residents and 8% of migrants, by contrast the percentages were 8,3% and 12% for domestic activities (Sen 1960).

2.6.2 TRADE

Commerce is another large employer. This can be partly

explained by the small amount of capital required for this activity. Moreover, capital can be obtained easily through personal credit in either cash or kind. Experience is not necessary and taxes can be easily avoided. For example, in Sierra Leone, whilst a large scale shopkeeper needs several thousands of leons (one leon is equal to $1.20) to set up a business and where a licence to operate a service station requires capital of one million leons, a small-scale shopkeeper needs onlyh from five to ten, a hawker from five to twenty and a market vendor from one to twenty leons (Isaac 1971).

Among the market vendors questioned in Fort Jameson, Rhodesia, 46% had less than a weeks experience (Rotberg 1962). In the Copperbelt 42% of the shopkeepers had never had another profession and 29% had less than one years experience (Miracle 1962).

In Mexico 26 000 urban shopkeepers had not bought the necessary licence (Benguin 1970). In Accra, Ghana in 1966 only 5 000 out of over 15 000 market vendors paid full tax for their stalls (Lawson 1967). In Peru many municipal authorities do not collect licence permits and taxes are only paid after a certain turnover is reached (Brisseau-Loaiza 1972); thus the smaller the business, the easier it is to avoid taxes. Market trade is

particularly undertaken by women, this being true of Latin America, Asia and especially Black Africa. The high percentage of women in the Laotian secondary can be explained by the law which prevents foreign men from owning factories, the women merely operate as a front for their Chinese or Thai husbands (Lejar 1971).

2.6.3 ARTISANS

The advent of mass consumption society and increases in industrial production have diminished craft activity throughout the Third World. This type of activity is much more vulnerable to the influx of modern products into the countryside and small towns (Sari 1968). In an urban milieu, and specifically in large cities, craft activities are better paid and also play an important role among the modern activities. Since self employment or family activities are often carried out in the home, taxes can easily be either partially or totally avoided. Moreover, these activities require little equipment and what is used does not need to be constantly updated. Though artisans are sustained by local demand, they are also able to adapt to demand fluctuations (Santos 1979).

Certain craft professions have large numbers. Tailors and dressmakers are found in great numbers, especially where

industry is limited and the price of imported ready-made clothing is high. In a sample of 755 working individuals in Bangui, 146 tailors were enumerated, 416 out of 3 526 self-employed merchants and artisans in the native quarter of Leopoldville (Kinshasa) approximately 300 tailors of the 1 400 working in various craft activities in the small southern Indian city of Tindivanan (Charleux 1970). At Onagadagou, Upper Volta, there were 400 tailors of the 16 000 workers (Pallier 1972).

2.7 INFORMAL SECTOR CHARACTERISTICS

Conditions under which modern economy develops and the existence of a massive and predominantly poor urban population, continually expanding as more and more rural migrants arrive, results in the maintenance alongside the modern circuit, of a non-modern economic circuit consisting of small scale manufacturing and crafts, small scale trade, and many varied services. Small scale production and trade are based on the buying, selling and transformation of small quantities.

Lasserde (1958) described the small scale trade in African districts of Libreville, capital of Gabon, as ***Unkempt little shops where cigarettes and sugar***

cubes are often sold individually." Family enterprises and self-employed individuals are the rule. The amount of capital invested is limited, technology generally out of date or traditional and the level of organization primitive. Profit margins, however, are high and many jobs are available. Since the system is based on non-institutional credit, cash is constantly in demand. Advertising expenditure is almost nil and few merchants bother to arrange their store windows (Portes 1987).

In this economy debts are much more common than bank deposits and where ***"Classical unemployment is unknown"..*** The organization of the informal sector has been ignored by many western observers, deterred by its apparently irrational and illogical management, control of operating costs and precise knowledtge of profits is uncommon and book keeping practically non-existent (Santos 1979). Lisa Peattie (1968) noted that in a shanty town of Ciudad Guyana none of the businessmen kept accounts, none of them are capable of doing so, and none of them are able to tell with precision what the sales were. This does not necessarily mean that they do not understand the general outlines of their economic

situations. While good management facilitates larger profits, it is not essential for a business survival (Orlove 1969).

The transport system of the informal sector is often obsolete, the truck, of course, is the primary means of transport, although its use may be limited by road conditions, cost and lack of merchandise requiring shipment. Also animals and man himself are often used for transport (Santos 1979). The equipment used in the informal sector is generally of poor quality due to the scarcity of capital. The sewing machine represents the capital investment of the tailor, but its relatively high price often forces him to rent one until he can purchase a second-hand, and a new model can be bought only when the business becomes more successful (Bettinghies 1965).

Craft production, the skills which are often passed from generation to generation, generally employs obsolete methods. For example, in Colombia, 47% of the leather workers of Medelin had been trained in and continued to use traditional techniques. Each production unit has limited product diversification and produces in small quantities. Fifty-three

percent of the artisans made only one article and fifty-six percent worked only when they had firm orders (Uribe et al. 1965).

In the informal sector most commodities are recycled and little is wasted. Lavoisier's formula about matter fits very well in the informal sector activities ***"Nothing is lost, nothing is created, everything is transformed."*** For example, old newspapers are used for packing, scrap pieces of wood are made into diaries, metal boxes are used to make flower pots. Clothing is handed down from father to son or from the older to the younger brother, whether or not the article was originally bought second-hand. In Lima, it has been observed that even the clothes of the dead people are sold or re-used and that exploitation of the city garbage is a source of income for 5 000 people (Santos 1979).

In the literature of the Third World urbanization the informal sector is called the ***Tertiary Sector".*** Tertiarization is the term now used to define activities and employment situations resulting from urbanization (Santos 1979). Some of the writers have critized these terms. Myron Frankman (1969) points out that the definition of services greatly

varies. Castells (1972) on the other hand considers the term ***Services*** misleading. Despite this criticism, the expressions ***Tertiarization, Tertiary*** and ***Services*** remain in general use.

The expression ***Lower Circuit*** appears to embrace much more of reality than the term tertiary sector. The lower circuit is more of a concept than a name, for it describes the result of a dynamic process and includes services e.g. ***Transport*** and ***Domestic Activities***) as well as craft forms of manufacturing (Santos 1979).

The ***Marginal Pole of Economy*** by Quijano (1974) called the primitive tertiary sector by Beaujeu-Garnier (1965) and the refuge tertiary by Lambot (1965) is a fundamental element of Third World urban life. Its importance lies in its roles as both a ***"pole"*** of attraction and a ***"sponge"*** for migrant and established residents both of whom are seldom able to find employment in the modern circuit.

The term small industry takes the number of employees as its basic criterion. Fryer (1963) for example, proposes that small industries in Malaysia be considered as having less than fifty employees or

less than twenty of machines are used. In Brazil the National Development Bank classifies small industries as having up to 99 employees (B.N.D.E. 1966). Kusmin (1969) suggests that fifth employees be the upper limit while Dwyer and Lay Chuen Xan (1967) place small industry between twenty and fifty employees.

The problem of a statistical definition stems from the difficulty of defining the criterion of smallness (Fisher 1907). Stanley (1962) prefers a definition which stresses functional characteristics and attempts to avoid any confusion between small scale industry and enterprises having local market.

Small industry includes all small scale manufacturing such as small factory and non-factory producers of the manufactured goods, modern and traditional enterprises, hand and machine types of production as well as urban and rural establishments. They recommended that establishments with one to nine employees can be called 'very small industry' and that this class of producers be included in statistics (Stanley and Morse 1962)

2.8 EMPLOYMENT AND ACTIVITY MULTIPLICATION IN THE INFORMAL SECTOR

The informal sector absorbs recent migrants and long term urban residents who lack either capital or skills. These people are able to obtain employment quickly although the jobs they find are generally marginal and insecure. The upper and middle classes tend to use more services when manpower is cheap, which together with fractionalization of both jobs and enterprises, multiplies certain employment possibilities and accommodates a large number of employment seekers such as shoemakers, tailors, small grocers and street vendors, rickshaw and taxi drivers, construction workers, shoe liners, drawers of water, night watchmen, grand boys and household servants. The situation in Tunis where sixty percent of the active population subsists on day to day basis substantiates this hypothesis (Eckert 1970).

The ramifications of the lower circuit's distributive systems are extreme. Geertz amusingly illustrates this for Java; ***"perhaps the best, if slightly caricatured image of a highly labour-intensive trade is that of a long line of men***

passing bricks from hand over some greatly extended distance to build slowly and brick by brick a large wall" (Geertz 1963). The lower circuit division of labour exists though different from that of upper circuit, in the lower circuit this entails fractionalization of activity and its corollary the multiplication of jobs (Santos 1979).

The informal sector activities, and particularly commerce, are carried out in a very large number of small sized enterprises. One research worker, on seeing the number of barbers in a Latin American shanty town, could not understand how these two-hundred persons could possibly earn enough money to survive (Orlove 1969).

The informal sector, besides being a refuge from destitution, also multiplies its activities. Once an entrepreneur needs bottles and cardboards to carry on his business, then some people may engage in collecting these and even employ people to take them to places where they are needed. Another important part of informatl sector is traditional healing.

2.9 TRADITIONAL MEDICINE

2.9.1 THE REGION OF AFRICA AND THE REGION OF SOUTH EAST ASIA

2.9.1.1 THE AFRICAN REGION (DR. C. RAMANOMISOA 1978)

The gradual development of traditional medicine activities in the African region and the decision to encourage them arose from the political events of the 1960s. With the advent of independence, Africans felt the need to rediscover their socio-cultural identity, traditional medicine as an integral part of their heritage benefited from this return to the fountain-head particularly because the inhabitants had never stopped making use of it despite the introduction of modern medicine by colonial powers. Moreover, economic circumstances made imported techniques and drugs less and less accessible, forcing the authorities to take a fresh look at the problem and study the possibility of using traditional medicine to improve the health situation.

It was, however, necessary to convince the political decision-makers that traditional medicine had something to offer, for whatever the technical

validity of a health programme, the success of its implementation is governed to a large extent by political decisions. The ***Regional Committee for Africa*** forwarded the following resolutions.

In resolution AFR/RC24/R14 the Regional Committee decided that the topic for the technical discussions at its twenty-sixth session in 1976 would be ***"Traditional Medicine and its role in the development of Health Services in Africa".*** The inclusion of experts in traditional medicine in the regional level panels set up in accordance with resolution AFR/RC25/R8 was further evidence of the wish to bring this heritage back into favour. Finally resolutions AFR/RC28/R3 invited member states and World Health Organization to take appropriate steps to ensure the use of essential drugs and medical plants of the traditional pharmacopoeia so as to meet the basic needs of the communities and ensure the development of the African pharmaceutical industry.

Following these resolutions, the Regional Office has given strong impetus or momentum to the traditional programme at both regional and national level. Different member states are endeavouring to set up a

mechanism for establishing close collaboration between the traditional and conventional systems and are making efforts to train and supervise the traditional practitioner so as to improve results and cut out harmful practices.

Three periods can be distinguished in the development of traditional medicine in the African countries. These are:

2.9.1.1.1 **PRECOLONIAL SITUATION**

This was the prime period for the traditional practitioners, when healers, fetishists and traditional midwives practiced their arts freely and were in any case sole guardians of the peoples health. Unfortunately, very little information has come down to us. 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.

2.9.1.1.2 **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 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.

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

2.9.1.1.3 **POST COLONIAL PERIOD**

The era of independence brought 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.

2.9.1.2 SOUTH EAST ASIA REGION (DR. HABIBUZ 1978)

The 29th World Health Assembly recommended action to encourage the development of health teams trained to meet the health needs of the population, including health workers for primary health care, taking into account, where appropriate the manpower reserve constituted by those practising traditional medicine (Resolution WHA 29.72). In persuance of this recommendation the Regional Committee for South East Asia regarded the regional director to organise seminars on traditional medicine to enable member countries to exchange information and experience about their respective systems of medicine and

discuss approaches for the best utilization of these systems in the provision of medical care to the population of this region (Resolution SEA/RC29/R11).

In May 1977, the 30th World Health Assembly adopted resolution WHA30.49 on the promotions and development of training and research in traditional medicine as an activity in the overall programme of the organization. The WHO Regional Committee for South East Asia, by its resolution SEA/RC30/R13 on traditional systems of medicine requested the regional director:

(i) To take steps for the implementation of the resolutions relating to the promotion and development of training and research in traditional medicine.

(ii) To provide facilities for the necessary training in traditional systems of medicine to health workers and to prepare protocols specifying the training, role and utilization of the manpower available in the traditional systems of medicine in the basic health care programme.

The International Conference on Primary Health Care held in Alma-Ata in September 1978 discussed the role of traditional medicine in primary health care and make recommendations for the promotion and development of traditional medicine where appropriate. In resolution SEA/RC33/R5 on drug policies, including traditional medicine, the Regional Committee requested the regional director inter alia, to continue assistance and technical co-operation with the countries in the evaluation, utilization and standardization of traditional medicines used in primary health care, in training programmes and in the dissemination of relevant information in the field of traditional medicine.

A WHO inter-country project was started in 1978 to collaborate with countries in the South East Asia Region in:

(i) promoting and developing traditional systems of medicine.

(ii) making maximum use of practitioners of traditional medicine for increasing the health coverage with particular reference to primary health care.

(iii) providing training for trainees of prospective traditional practitioners

In addition to providing a number of fellowships to teachers of institutions of traditional medicine in Bangladash, Nepal, Sri Lanka and Thailand, a significant number of institutions in these and some other countries in the region of South East Asia have received sets of books on traditional medicine in primary health care. Another important activity was the holding of an inter country consultative meeting in New Delhi in April 1979. The meeting listed the following as constraints in the use of traditional medicine.

(i) Inadequate knowledge of modern methods of preventive and promotive health care among traditional practitioners.

(ii) Lack of homogenity between traditional and modern methods in this field.

(iii) Insufficient knowledge on the part of traditional healers and even trained and qualified practitioners in different aspects of curative and

preventive health care.

(iv) Absence of standardization of traditional drugs

(v) Lack of active involvement of traditional practitioners in many health care programmes supported by adequate referral systems.

(vi) Lack or organization for the procurrent and supply of raw drugs and compound formulations.

(vii) Non-availability of basic guide books and manuals on common ailments.

(viii) Lack of adequate information and mutual exchange of information between practitioners of modern medicine and those of traditional medicine.

Taking note of the inherent advantages of the traditional systems of medicine, the meeting made a number of detailed and specific recommendations in regard to:

(i) The use of practitioners of traditional healing in primary health

care.

(ii) Their training including that of traditional birth attendants.

(iii) Directions of research in traditional medicine

(iv) Exchange of information

(v) Collaboration between countries and various international agencies.

In the implementation of the various resolutions adopted by the Regional Committee, a number of short-term consultants were assigned for various periods to study the situation in respect of traditional medicine in nine countries of the region i.e. Bhutan, Bangladesh, Burma, India, Indonesia, Maldives, Sri Lanka and Thailand. In general, the tasks assigned to them were:

(i) to investigate the place that traditional medical preparations have in ongoing or planned primary health care programmes and activities.

(ii) to report on the training of primary health care workers in the use of traditional medicine and suggest improvements as necessary.

(iii) to study the factors that determine the availability of traditional medicines at the primary health care level and recommended measures to improve the situation as necessary.

(iv) to compile a list of traditional medical herbs in different countries of the region so that each country's experience could be of mutual benefit.

(v) to identify individuals and institutions which may be capable of carrying out research in traditional medicine and to stimulate nationals to submit protocols for research in the areas of priority already indicated by the Regional Advisory Committee of Medical research.

Since the ongoing inter country project became operational, several countries in the region have taken active steps in developing a national programme in traditional medicine, Burma and Sri Lanka being the most prominent in this respect. In Indonesia and Thailand some traditional medicine in the basic rural health service structure at the

health post level are being studied.

In the meantime, another inter country project (Medical Herbs and Ayurvedic Drugs) funded by the United Nations Development Programme and meant for the least developed countries became operational during 1980. This project had limited objectives to be achieved by 1982 in three countries i.e. Bangladash, Butan and Nepal. Continuing support for the ongoing intercountry project will be required to sustain these collaborative activities in the other countries of the region such as Burma, Indonesia, Maldives, Sri Lanka and Thailand and to provide further incentive to the WHO/UNDP programme in traditional medicine in Bangladash and Nepal.

2.9.1.2.1 THE FUNCTIONING OF MAJOR SYSTEMS OF TRADITIONAL MEDICINE IN SOUTH EAST ASIA REGION

The major systems of traditional medicine in this region can be classified as:

(i) ***Formalized systems of indigenous medicine*** which include Ayuverda,

Siddha, Unani Tibbi, the Chinese system of medicine and the Tibetan system of medicine.

(ii) ***Non-Formalized Traditional Systems of Medicine*** that is practiced by herbalists, bonesetters and practitioners of thaad (element system) home remedies and spiritualists. Almost all the countries in the region have recognized the traditional systems of medicine and are making efforts to utilize the practitioners in their health care delivery programmes. Presently 750 000 practitioners of traditional systems of medicine are found in the region. Below is a discussion of the functioning in each of the countries.

2.9.1.2.2 **BANGLADASH**

There are mainly two systems practiced in this country. These are *Unani* and ***Ayurveda.*** A board has been set up for issuing registration for maintaining the standard of teaching institutions and for

encouraging the research. There are over 5 000 registered practitioners in addition to unregistered 3 000 practitioners. Only 540 practitioners are qualified institutionally, there are four institutions which impart training in Unani and ayurvedic systems of medicine.

2.9.1.2.3 **BURMA**

Nealry 30 000 traditional medical practitioners provide medical care to about 85% of the population of the country. An indigenous medical institute and hospital is run by the government as well as 34 dispensaries devoted to indigenous medicine which operate in different parts of the country. There are 11 227 trained and about 22 000 non institutionally trained practitioners in the country in addition to about 43 000 birth attendants. The government believes that the development of indigenous medicine will gain momentum through its proper utilization in community medicine and modern medicine.

2.9.1.2.4 **INDIA**

The traditional systems practiced in India include

Ayuverda, Siddha, Unani, Yoga and the Naturopathy and Tibetan systems of medicine. These systems have been recognised by the government for the purpose of national health services. There are 108 undergraduate teaching institutions in traditional systems of medicine awarding a degree following training for 4½ years in Ayuverda/Unani/Siddha. There are two post graduate institutes and twenty one post graduate departments awarding postgraduate degrees and doctorates. There is an exclusive ayurveda university at Jamnagar in Giyarat. It is the only one in the world.

2.9.1.2.5 **INDONESIA**

The traditional practitioners in Indonesia are the Sukun Bayi and traditional healers who mostly use herbal medicines in their treatment. A school of traditional medicine is run by the government. A directorate for the control of traditional drugs has been established and research into the use of these drugs is also being conducted in the pharmacology functioning in the country. The Ministry of Health has registered 25 pharmaceutical companies producing traditional drugs. The government recognizes that there is a great body of knowledge available among

traditional healers on the treatment of various diseases and also for promoting health.

2.9.1.2.6 **MALDIVES**

The system of traditional medicine prevalent in the Maldives is a mixture of Arab medicine and other system practiced in the other countries of India and Sri Lanka. Most of these practitioners are located in the rural areas.^R *^U(^T^U(*(dicine is much in use. There are 151 practitioners of traditional medicine. Only two practice unani medicine. There are no government hospitals or dispensaries and no formal training programmes available.

2.9.1.2.7 **NEPAL**

In this country ayurveda is practiced. There are 82 ayuverdic clinics. About 75% of the population resort to ayurveda treatment. Facilities are available for intensive education in this system, there is a three-year certificate course. There are 200 institutionally qualified practitioners and about 1 000 traditionally trained persons. Drug research and survey activities have taken up.

2.9.1.2.8. **SRI LANKA**

There are three traditional system of medicine in Sri Lanka. These are Avurveda, Siddha and Unani being practiced by 3 500 institutionally trained and 14 700 non-institutionally trained physicians. There is a government Ayurvedic College which provides five years of systematic education to about 150 students every year. Research activities have been conducted at the Bandaranaike Ayurvedic Institute in 1962. There are four government ayuverdic hospitals, four dispensaries and 240 institutions. The practice of traditional medicine is controlled by the government act. Drugs are being produced by several establishments on a commercial scale.

2,9.1.2.9 **THAILAND**

In Thailand all the 35 000 traditional practitioners are registered. There are no recognised training institutions. Traditional practitioners are not utilized by the government for delivering health services at any level in the country. The government is pursuing several research projects to study the section of various plants available in the

country.

2.9.2 THE ROLE OF TRADITIONAL MEDICINE IN PRIMARY HEALTH CARE (BANNEMANN)

Primary health care is essential health care based on practical scientifically sound socially acceptable methods and technology. The principles that are necessary for its effective development require a multisectoral approach as determined by various activities and facilities. It is the main vehicle through which an acceptable level of health and near total coverage can be achieved in the foreseeable future.

Primary health care is concerned with the main health problems in the community and the services reflect the political and socio economic pattern in the country. In order to make such care readily accessible and acceptable in the community, maximum self-reliance and community participation for health deployment are essential. Such involvement enables communities to deal with their health problems in the most suitable ways and community leaders are in a better position to make rational decisions concerning primary health care and to ensure

appropriate support for health and allied projects. Primary health care workers should, whenever applicable, include traditional practitioners, healers, birth attends etc.

The developing countries pose a picture of want and deprivation with inadequate resources, a dearth of manpower and no definite hope of amelioration in the forseeable 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 incoporation of tradiitional practitioners into the health team.

In many of the developing countries there is a widespread disenchantment with health care for various reasons which are common to nearly all the developing countries. Health resources tend to be counter-acted in urban areas, which accommocate only about 20% of the total population. These facilities are so expensive that only the elite and opulent citizens in the city can afford to avail themselves of the specialist services utilizing such costly technology.

A number of developing countries in Africa, Asia and Latin America are exploring the possibilities of developing their wellknown and tested herbal medicines for use in primary health care centres. These medical 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. The high cost of primary health care has become such a major constraint that what is regarded as basic in health services in the developed countries is considered specialized service in a developing country.

In many of the developing countries primary health care devolves on the healer, herbalist, taditional midwife and other traditional practitioners. These are health workers who offer services to the disadvantaged groups that total about 80% of the world's population and have no easy access to any permanent form of health care. Traditional medicine therefore has a major role in primary health care in terms of numbers of people served by that care system throughout the world and in spite of any defects. The traditional healers are the true

community health workers in their society.

2.9.3 CATEGORIES OF TRADITIONAL PRACTITIONERS

There are four main categories of traditional practitioners. The first category is that of those who have received a fully integrated training in modern and traditional systems of medicine. These are practitioners of such systems as Ayurvedic, Unani, and Chinese medicine.

The second are those trained mainly in traditional medicine but who also have elementary knowledge of modern medicine. Such health workers practice mainly as smaller rural communities using traditional medicine in general and modern allopathic drugs in emergency situations.

The third group are traditional healers without formal training but who have obtained diplomas in some particular traditional system. They practice only traditional medicine.

The fourth group comprises those without either institutional training or qualifications and who practice traditional medicine after several years of

apprenticeship with an established traditional practitioner. These include traditional midwives and some herbalists.

2.9.4 THE ZULU MEDICINE-MAN, NHIS STATUS AND INITIATION

Compared with the sleek and imposing personality of the chief, the medicine-man presents quite a mean appearance, though picturesque and awesome withal. Along with the chief he shares the greatest power in the savage tribe. This is not power of supreme authority, but a power of life and death not less effective and real, though hidden and mysterious. His well wrinkled features bear the unmistakable stamp of a thinking mind and his intelligent eye has that flash of deep cunning so well suited to mean who has so often been the accomplice, behind the scene to sinister deeds. His lean, wiry frame betokens a life of toilsome, if well rewarded, activity rather than of luxury and repose, an activity consisting mainly in constant arduous journeyings throughout the land and frequently even with foreign lands of adjoining tribes.

Out in the full panoply of a professional progress, his body is betrimmed with a medley of the most fantastic trappings. A plume of feathers waves above his head-ring, and a circlet of lion claws surrounds his neck. Various cow-tails dangle from his arms and chest, supplementing the square strip of leopard skin and the bundle of genet tails that cover his nakedness behind and before. Numerous branches of goat horns, blackened with smoke of his hut and sundry small grass woven basket and bundles of rag-packages, brown with dirt, containing his strange assortment of drugs and charms, are strung from every point of vantage about neck, shoulders and body. A long pouch, holding his snuff box and made from his left hand and in the other he carries his long walking staff or a couple of stout sticks.

Thus, silently followed by his menial, bearing his head on his master's roll of sleeping mats, blanket, smoke horn and head rest, the Zulu medicine-man goes forth to conquer death or to administer it. The high dignity and diploma of the medicine man is open to all who may have the wealth and inclination to seek it. Lack of ambition and individual initiative is a chief characteristic of the African nature and accounts for the utter absence of young men,

launching out on independent projects of their own. But should one per chance be so precious as to aspire the medicine man's estate, he must undergo a long period of initiation. He enters the service of some doctor of repute as his ***Impakuta*** or ***Uhlaka*** or ***Assistant.*** His business is to act as a messenger, the herb gatherer and general helper of his master in professional matters accompanying him on all his excursions as medicine bearer, and picking up by observation and instruction whatever of knowledge and skill he can.

In an irregular way this kind of study may go on for years, until at length the tyro feels that he is capable of dealing with a good many ailments on his own account, pays his master a required fee of two or three head of cattle and betakes himself to his own home where he soon surrounds himself with a comfortable practice. He constantly adds to his store of knowledge by consultation and mutual exchange of remedies with neighbouring doctors, until, after perhaps twenty years or more, he has picked up all that is worth knowing in the Zulu pharmacopoeia and pathology. All this is rare and exceptional course. As a matter of fact, the medical profession is with the Zulu's hereditary,

one of the medicine-man's son being compulsorily introduced by him into the trade as his assistant, during life and inheriting his legacy of bags and bundles of medicine after his death.

2.9.4.1 THE ORIGIN OF THE ZULU NAME - INYANGA

The medicine man among the Zulus is called an ***Inyanga.*** In Xhosa they are called ***Inyangi*** or ***Igqira.*** The word igqira is more common in Xhosa than inyangi. It is derived from the Hottentot c.f. ***Nama-Hot "Gqeira"*** pertaining to witchery, from ***Gqei-Di,*** bewitch, from ***Gqei*** which means belch. The universal habitat among witch-doctors, Zulu included of inaugurating their spiritualistic seances with an inevitable prelude of belching.

Whether or not there may be any kinship between the native roots indicated above and the constantly recurring element AG, GA or GI in the Aryan languages e.g. SKR, GIR speech; PERS. MAG, priest, GR.Magos, wizard; L.Augus, soothsayer; GA-RIRE, chatter; ENG.Mag chatter etc Certainly a remarkably similar element, viz. ANGA, in the sense of WIZARD or MEDICINE MAN is very prevalent in the present day

vocabulary of the nasalising Bantu tribes of Africa and was no doubt equally so in the archaic speech of pre-Egyptian times.

Thus we find ***M-Ganga*** (Doctor) in the Swahili opposite Zanzibar, and the smake ***Kaguru*** of Sagaraland. The ***Nyamnyam*** of the Nuba-Fula group have ***N-Zanga*** (doctor) and ***Wu-Wang*** (medicine). Passing to the Hausa, of the negro group, between Lake Tshad and Niger we have ***Magani*** (medicine) and ***Maimagani*** (doctor). In the Dualla of the Cameroons, BW-ANGA means medicine and in the Pongwe or Gaboon language U-GANGA appears as doctor. Moving southward along the western coast, we meet with ***N-Ganga*** (doctor) both in the Congo and Angola speech. Still southward of these at the south western extremity of the Bantu field, the Herero has ***On-Ganga*** (doctor. Returning across the continent, we find ***N-Gaka*** (doctor) among the Sutos ***In-Ganga*** (doctor in Mashonaland; the same again among the Tonga seaward of Victoria Falls; and there is ***Un-Ganga*** (doctor) among the Nkonde north of Lake Nyasa.

2.9.4.2 THE INYANGA AND WITCH-DOCTOR COMPARED

Among most primitive peoples the inyanga, the priest

and deviner was and still generally is, one and the same individual, following the one indivisible trade. All powers and functions that possessed about them anything of the mysterious and uncanny, whether they were employed to eradicate disease or to reveal hidden doings, to bestow good fortune or to charm away the bad, were to the savage mind so identical in their nature as to be the most properly combined in the same profession and same professional. They were but varied manifestations of the one same power.

The African medicine man, as called by Europeans, may therefore very possibly be the direct descendant of the aboriginal 'priest' who worked at once moon, medicine and magic. With the Zulus and Xhosa, however, the office throughout all historical time has been divided.

The Zulu medicine man or inyanga is a personage totally distinct from the Zulu diviner or so called witch doctor. Even so, the two professionals do still considerably overlap, the inyanga dealing very largely in magic and charms and conversely the witch-doctor possessing an extensive acquaintance with disease and currative herbs, although his

office is rather to indicate than to actually administer. Both are commonly called an inyanga though the medicine man is sometimes distinguished as ***Inyanga Yokwelapha*** (doctor for curing) and the witch doctor as ***Inyanga-Mthakathi*** (a doctor that bewitches).

2.9.4.2 **CONCLUSION**

In South Africa traditional healing is no longer a practice that is mainly prevalent in the rural areas. Today, because of the movement of people to the cities in their numbers, traditional medicine has become part and parcel of urban life. A very large percentage of urban dwellers depend on this type of medicine for their primary health care.

It is, however, important to note the differences that obtain between the practice of traditional healing in the old Zulu system. One remarkable difference is that the payment for services is totally not the same. In the olden days a person would pay by giving a medical practitioner livestock for his services. Today money is used in exchange for medical services.

Another difference is in the ways of obtaining the required drugs by the healers. In the olden days the medicine man would go out with his assistant or ***Uhlaka*** and collect the herbs from the forest or the bush. In the cities today the selling of herbs and drugs have become one of the main economic activities.

It is notable, also, that the government in South Africa does not take any effective recognition of traditional healing for delivering health services at any level in the country.

CHAPTER 3

METHODOLOGY

3.1 INTRODUCTION

The informal sector is one of the main alternatives used by the urban unemployed in most of the Third World cities. Because of the great numbers of people flocking into the cities in the Third World countries, the cities are failing to provide jobs for all these people. It is from this point of departure that most of the urban unemployed in the cities of the Third World decide on alternative means of making a living. In this chapter the methodology used in the study of traditional healing as part of the informal sector at Umlazi township will be explained.

3.2 THE AIM OF THE STUDY

The aim of the study is to make an investigation of how the traditional healers operate at Umlazi township with special reference to their socio-economic status, system of operation and their future plans.

3.3 OBJECTIVES

Some of the objectives of the study are to:

(i) Examine the extent to which traditional medicine as part of informal sector absorbs the unemployed in the township of Umlazi.

(ii) To investigate the requirements needed for entry into the business of healing.

(iii) To determine the nature of services provided by the informal healers.

(iv) To investigate problems which the healers experience in this activity by way of

(a) determining the socio-economic status of the traditional healers

(b) identifying the type of training undergone by informal healers.

3.4 HYPOTHESIS

It is hypothesised that:

(i) The main reason for engaging in the traditional healing activity is the lack of jobs.

(ii) There is easy access into traditional

healing activity

(iii) A wide range of services are provided by the traditional healers

(iv) The main problem experienced by healers is that of absconding

3.5 THE STUDY AREA

According to information provided by the township manager's office at Umlazi, this area was once known as ***Umlazi Mission Reserve.*** It was occupied by Black families living under rural conditions. Most of these Blacks, however worked in Durban city. The area was divided into tribal districts with each under a chief appointed on hereditary basis. The main districts were kwa-Ndosi under Chief Cele and kwa-Nyuswa under Chief Mqijima Nyuswa.

In the early 1950s some 1 200 houses were built by the Natal Housing Board. When the shortage of housing for Black employees became serious, the ***State Department of Bantu Administration and Development*** in 1961 embarked upon a scheme to develop the whole area so as to house Blacks working in southern industrial area of Durban. Most of the resettled Blacks were from the shack conditions of

Cato Manor.

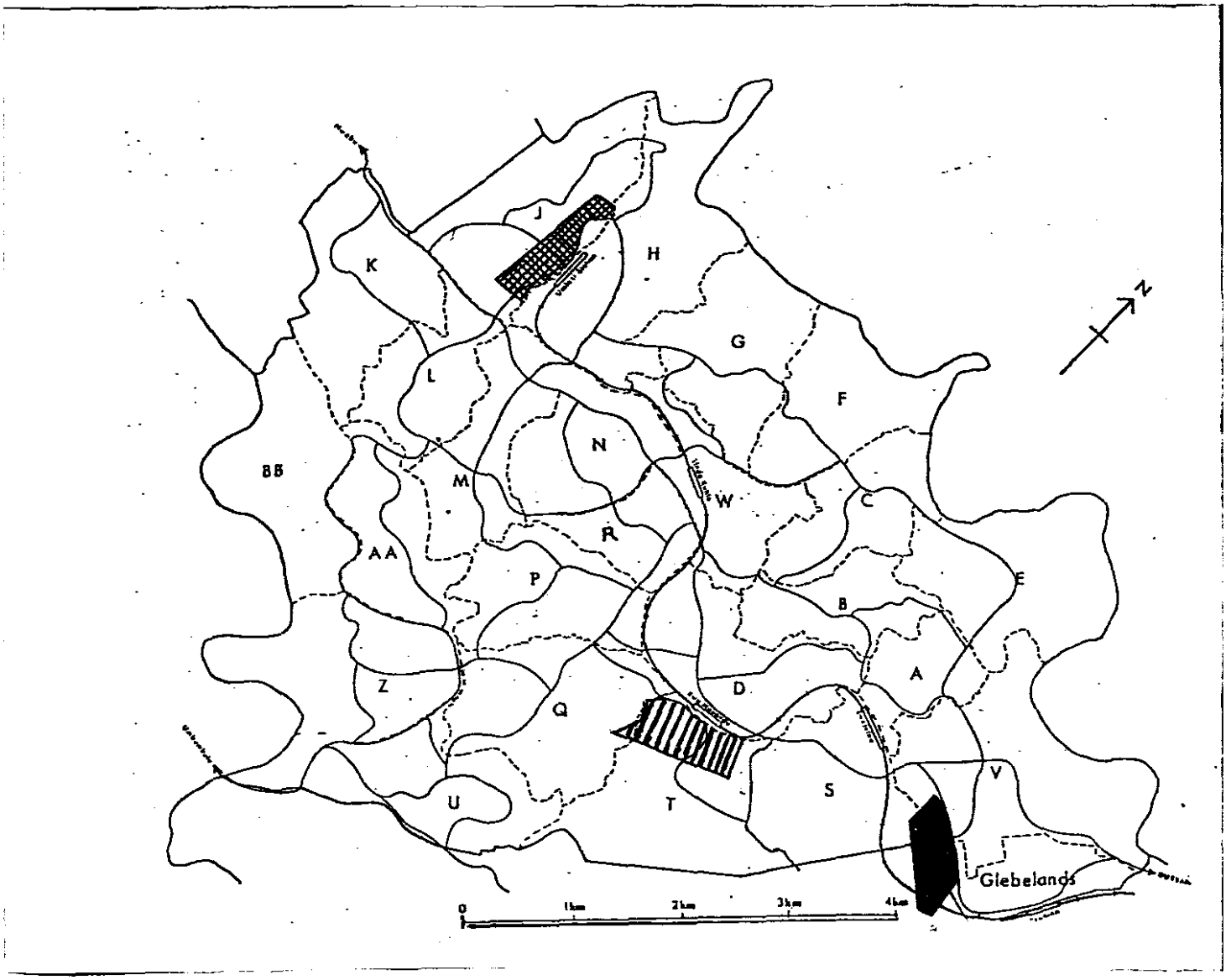
Arrangements were made between the Department of Bantu Administration and Development and City Council of Durban to develop the township. The City Council of Durban, acting as agents of South African Bantu Trust undertook to provide technical and engineering staff. The township was planned on basis of eighteen neighbouring units. Each of these units was supposed to have its own centres for shopping and recreation. Today, in spite of the shopping centres that operate formally, there are also some shops that are run in ways that are informal. While the township has about four clinics, a hospital known as ***Prince Mshiyeni Memorial Hospital*** and a number of surgeries as medical institutions, there are centres of traditional healing, business. These are ***Umlazi Glebe; Umlazi Station*** and ***kwa Mnyandu Station*** as shown in Fig 3.1.

Umlazi township is about 11,5 km west of the Indian Ocean and about 20 km south west of Durban city. In the north there is Umlazi River which forms a boundary between Umlazi and Lamontville. In the south there is Izimbokodo river forming a boundary

between Umlazi and Umbumbulu rural settlement. It is important to note that the Indian Ocean has a great influence on the climate of Umlazi both in summer and winter.

A small developing down called ***Isipingo*** is situated south east of Umlazi. There is a highway known as ***Mangosuthu Highway.*** It links Umlazi with Durban city, Jacobs, Isipingo and the rest of South Africa. Umlazi is also linked with other areas through an electrified railway line from section J and H through the township and to Durban (see Fig. 3.1). Figure 3.2 shows the position of Umlazi in relation to Durban, Isipingo and the Indian Ocean.

3.1 THE MAIN HEALING CENTRES AT UMLAZI (1990)



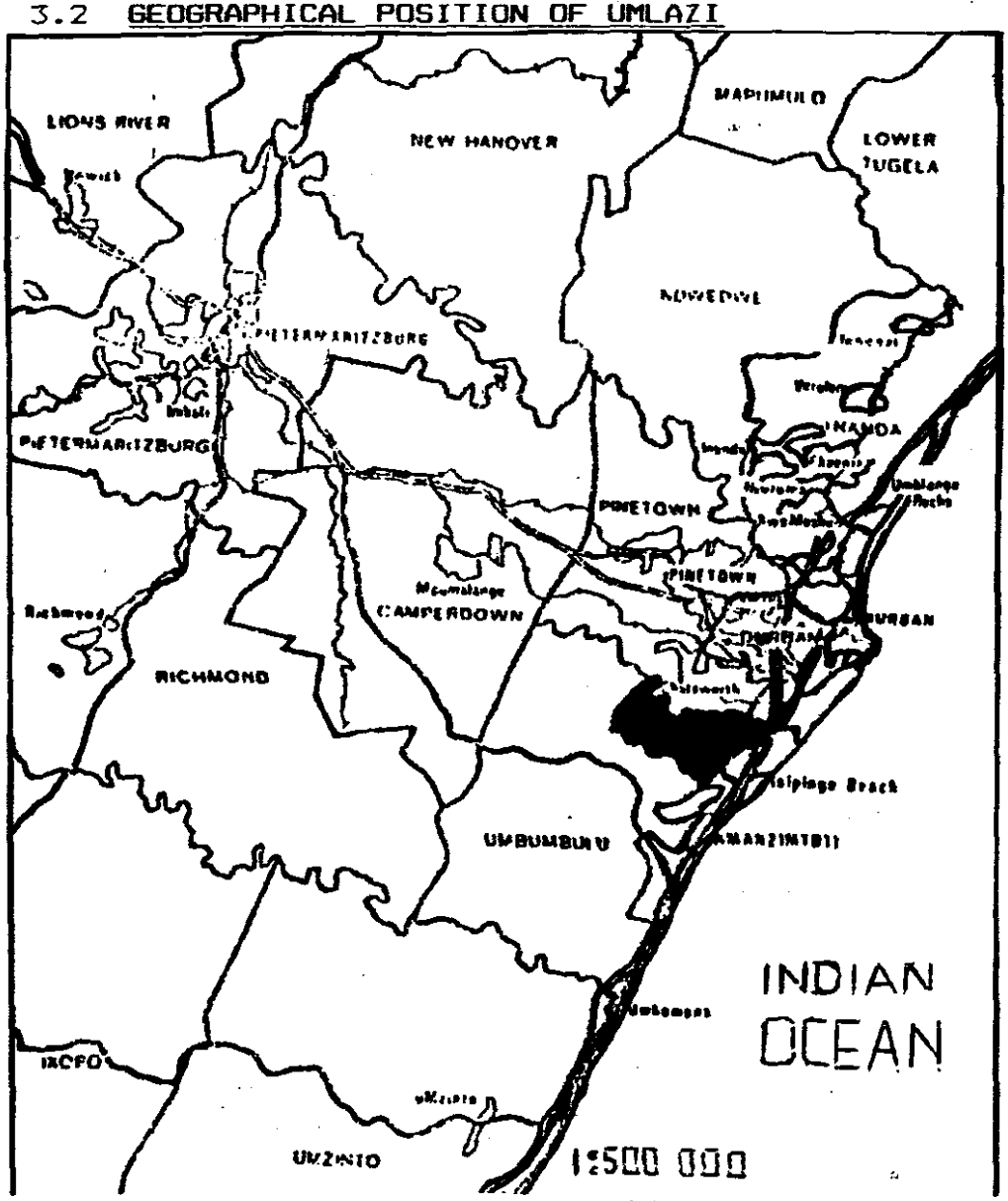
SOURCE: TOWNSEND

UMLAZI STATION

KWA-MNYANDU STATION

UMLAZI GLEBE

3.2 GEOGRAPHICAL POSITION OF UMLAZI



SOURCE: THE DEVELOPER (K.F.C.)

KEY

= UMLAZI TOWNSHIP

SOURCE: THE DEVELOPER (K.F.C.)

3.6 SAMPLE

As a result of the situation found in the centres of informal healers, it was difficult to apply formal procedures in sample selection. In the whole of the township there were about 500 traditional healers. It was necessary to approach Mr Ngcobo, a herbalist who runs a traditional chemist at Reunion area. Mr Ngcobo provided leads to forty healers. Only thirty of the forty healers responded.

3.7 DATA

A structured questionnaire was used to obtain the necessary information (see appendix). The questionnaire was divided basically into three parts. Part A dealt with the *Socio Economic Characteristics* which included *Age and Sex, Number of Dependants, Family Members Involvement, Place of Residence, Transport Used, Cost of Transport, Income, Level of Education, Training and Previous Occupation.* Part B had to do with *Traditional Healing* including *Working Conditions, Types of Services offered, Advertising, Record keeping.* Part C included problems encountered in the activity, type of customers as well as future plans. Open

questions were asked with an aim of determining the extent to which traditional healing relates itself to informal business.

3.8 PROBLEMS ENCOUNTERED

It was difficult to find those healers who worked at their homes. As a result very few were interviewed.

Some healers were reluctant to participate in an interview because they believed that it would reveal their healing secrets.

Some healers were scared to answer some of the questions as they thought that their illegal practice in the healing centres was to come to an end.

CHAPTER 4

4.1 INTRODUCTION

In this chapter attention is directed at the findings of the study. The following findings will be dealt with: age-sex-distribution of healers at Umlazi Township, level of education, income, number of dependants, family members involved in healing, places of residence, transport, transport cost, type of training, place of training, working hours, working days, previous occupation, reasons for being in the activity, type of engagement, keeping of records, terms of payment, problems experienced, customers, views on serving in formal medical institutions and future plans.

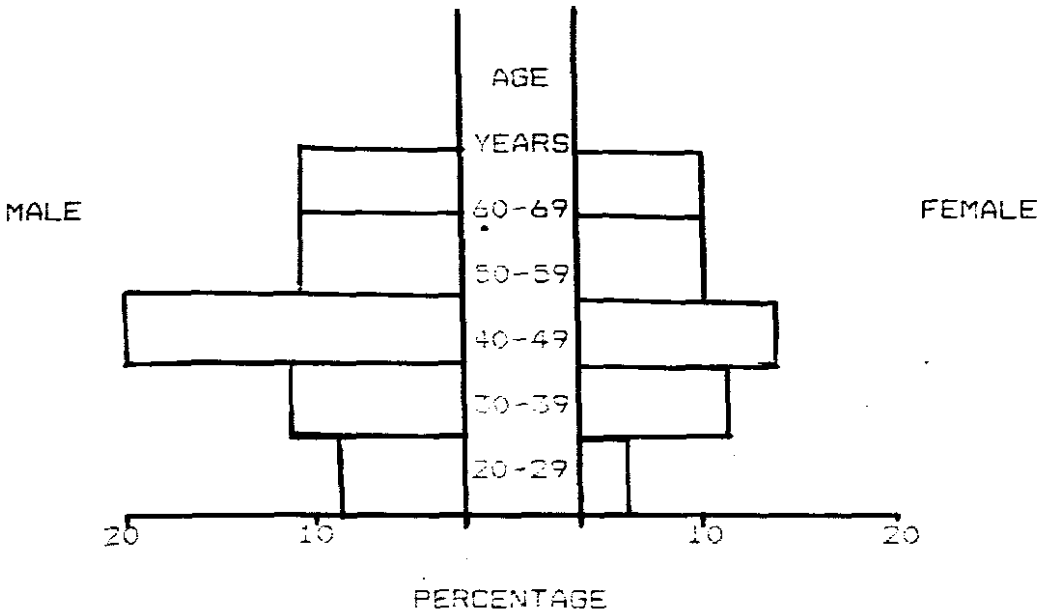
4.2 SOCIO-ECONOMIC STATUS

4.2.1 AGE-SEX DISTRIBUTION

Thirty traditional healers were interviewed. All worked at the following centres. Umlazi-Glebe 42%, kwaMayandu Station 54%, Umlazi Station 2% and at residential areas 2%. Their ages ranged from 18 years to above sixty years. Those who were above

sixty claimed to have been in this activity for a very long time. Their mean age was 44 years. Sixty percent of the healers interviewed were males. The remaining 40% were females (Figure 4.1). A total of 37% of healers were between 40 and 50 years of age.

4.1 AGE-SEX DISTRIBUTION



4.2.2 DEPENDANTS

Most of the healers had dependants. Table 4.2 shows that 53% of the healers had more than seven dependants and only 10% had less than three dependants. The mean was 5 dependants. Seventeen percent of the healers had less than seven dependants. This shows that most of the healers had

quite large families to support. Some of the healers were the only working people in their families, and hence their livelihood depended on traditional healing.

TABLE 4.1 NUMBER OF DEPENDANTS

DEPENDANTS	PERCENT
0 - 2	10
3 - 4	17
5 - 6	20
TOTAL	100

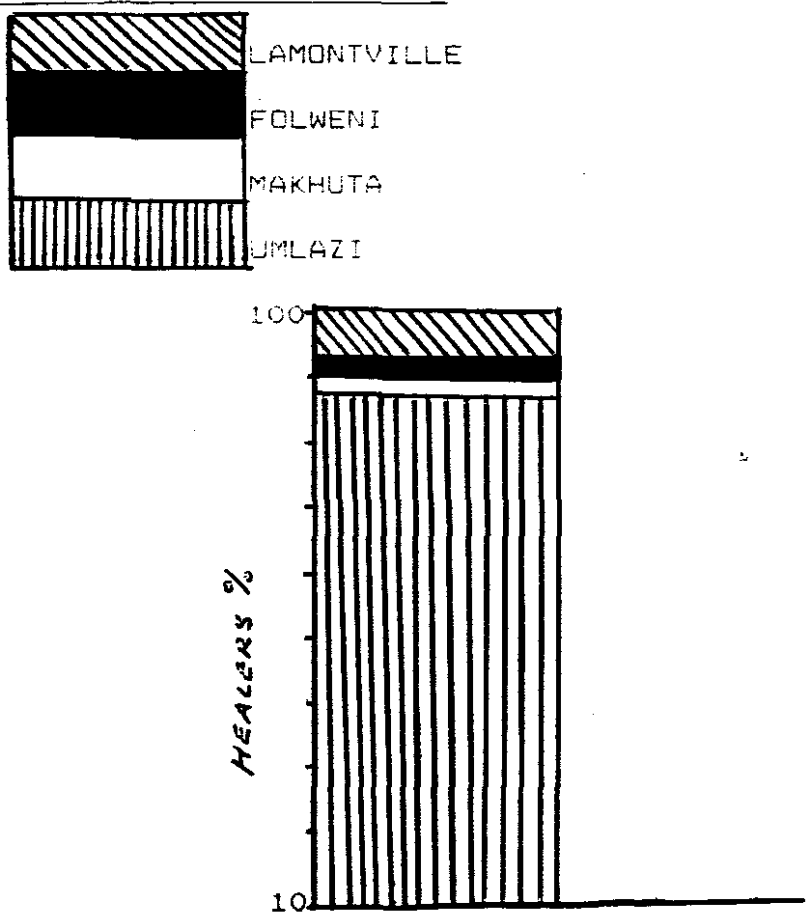
4.2.3 FAMILY MEMBERS ENGAGED IN THE ACTIVITY

The study revealed that the majority of healers had no dependants or other family members who were involved in this activity. Only 30% of the healers had family members who assisted them in working. The main reason given for this was that most of the family members were still attending school and some were still looking for jobs. This situation is partly a result of the fact that most of the healers had young children who viewed traditional healing as an archaic way of working.

4.2.4 PLACE OF RESIDENCE

Healers resided at different places. The majority of healers, 87%, lived at Umlazi Glebe and Unit 17 Umlazi which is known as *Section T* (see Figure 3.1). These are areas where migrant labourers lived. The other healers lived in the township of Umlazi. Figure 4.2 shows that there were only 13% of the traditional healers who came from places outside the township.

FIGURE 4.2 PLACES OF RESIDENCE



4.2.5 PLACE OF BUSINESS

There were three main places of business. Two percent of the healers worked at their homes. Forty-two percent worked at ***Umlazi Glebe*** and 54% worked at kwaMnyandu Station. Table 4.2 shows that many healers worked at Umlazi Glebe and kwaMnyandu Station. These serve as reception areas for rural migrants some of whom resort to any type of informal activity, including traditional healing when they fail to find jobs in the formal sector.

TABLE 4.2 PLACE OF BUSINESS

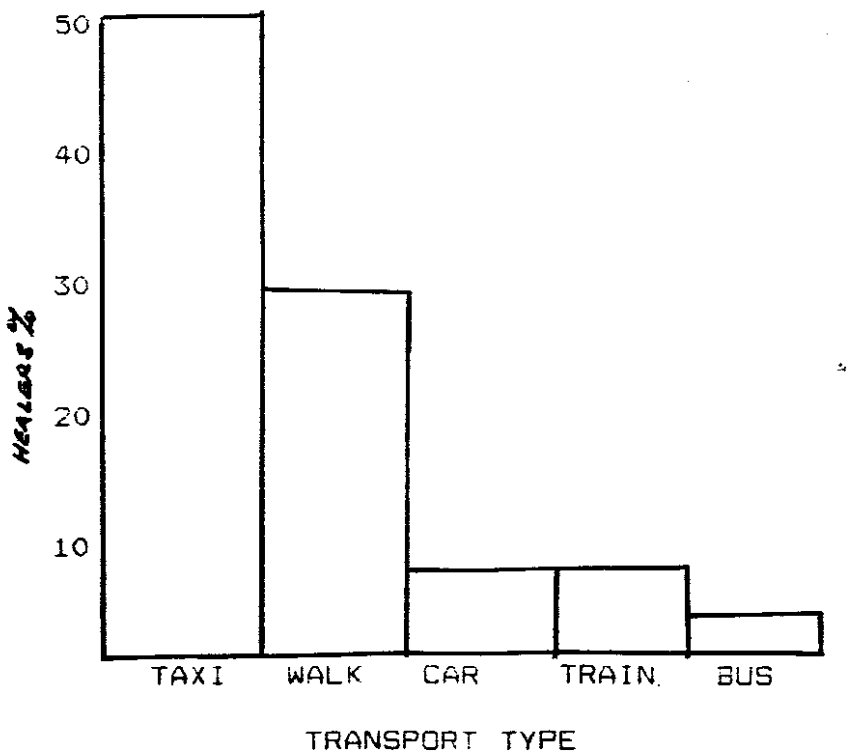
PLACE	PERCENT
HOME	2
MNYANDU STATION	54
UMLAZI GLEBE	42
UMLAZI STATION	2
TOTAL	100

4.2.6 TRANSPORT

The traditional healers used different modes of transport when going to their places of work. Figure 4.3 shows that healers travelled to work through taxis, private cars, trains and walking.

Those who used road transport travelled by buses, private cars and taxis. The most widely used type of transport were taxis. Fifty percent of healers used taxi transport. The reason why most of the healers used taxis was that they were always available and they did not operate on time schedule like buses and trains. Most of the healers did not have a fixed time for starting business. One third walked to their places of work. Less than 10% of the healers used private cars.

FIGURE 4.3 TRANSPORT USED BY HEALERS AT UMLAZI



4.2.7 COST OF TRANSPORT

The fact that traditional healers at Umlazi used different modes of transport meant that costs of travelling also varied. Most of the healers used taxis and this was the most expensive form of transport. Those who walked to their places of work did not have any expenses related to transport. Many healers who worked at kwaMnyandu station were from section T mens hostel and nearby sections such as P and Q (Figure 3.1) and some lived in shacks at the station. The same applied to those healers who worked at Umlazi Glebe and resided at Glebe men's hostel. On the whole, the majority of healers did not have very high transport costs. Only 7% paid more than R79 per month (Table 4.3).

TABLE 4.3 COST OF TRANSPORT

COST	PERCENT
R50>	73
R50-R59	17
R60-R69	3
R70-R79	7
TOTAL	100

4.2.8 MONTHLY INCOME

There was a great difference in the monthly income per healer. Their income ranged from R100 up to R600 and more (Table 4.4). Income depended on advertising, the geographical situation of their working places, the number of working hours per day and the number of working days per week. Weather also played a role in determining their monthly income. Some of the healers did not have shacks and shelter. They worked in open air. Therefore on windy and rainy days their businesses were affected. Those who had shelter were able to work throughout the month. The mean monthly income was R351.

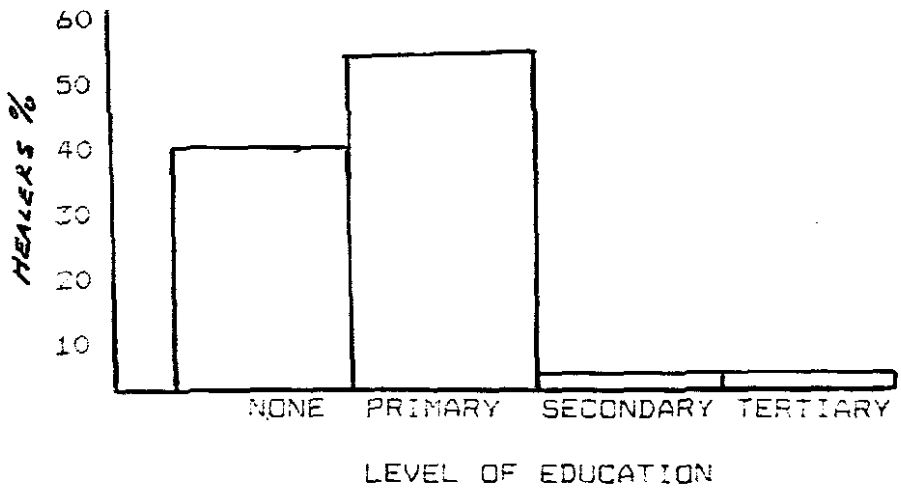
TABLE 4.4 MONTHLY INCOME

INCOME	PERCENT
R100	33
R200	1
R300	10
R400	13
R500	7
R600+	36
TOTAL	100

4.2.9 LEVEL OF EDUCATION

The majority of healers had very low standards of education. Forty percent of the healers at Umlazi township did not go to school at all. Fifty -three percent of the healers attended school as far as primary level. Only 3,5% of the healers had received secondary and tertiary education respectively (Figure 4.4).

FIGURE 4.4 LEVEL OF EDUCATION



4.2.10 **TYPE OF TRAINING**

Most of the healers at Umlazi township did not undergo formal training. They served an apprenticeship under an established healer for a number of years thus getting their training in the process. A total of 97% of healers did not receive

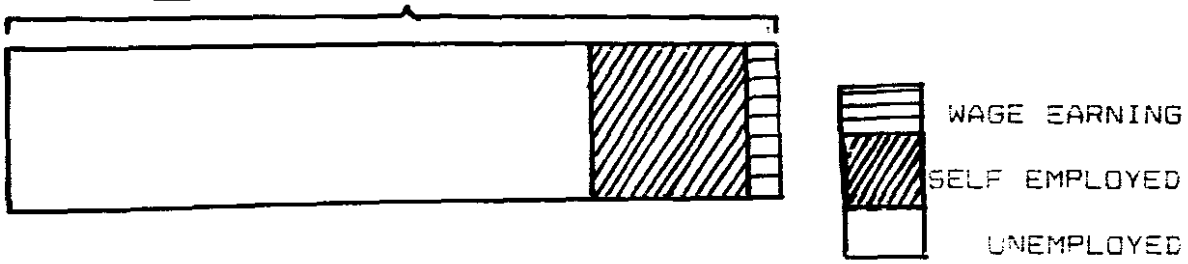
any formal training. They sometimes spent weeks at different places in Natal, Transkei and other places where they got more training but this was also informal. Some even went back to places where they received their initial training to be given new skills of healing. Some waited until their ancestors gave them direction as to where to go in order to get new techniques of healing. Some of the healers received their training in the city when they could not find jobs and while away time by helping established healers. Eighty percent of the healers received their training in rural areas. Those who received training in the city constituted 20% of the total number of healers.

4.2.11 PREVIOUS OCCUPATION

Healers at Umlazi township came from different walks of life. Seventy-three percent of the healers were once employed in industries. Twenty percent were self employed from the time they came to the city. Some of those who were once employed in industries, were called into the activity by ***Idlozi***. This happens when a person falls sick for a very long time. The type of sickness cannot be cured by a medical practitioner. At the final attempt he is

taken to the bone scatterer who would confirm that the person was being invited by the spirits into traditional healing. Some were unemployed since they came to the township. At the same time they had some knowledge of traditional healing. They then decided to use their knowledge of healing (Figure 4.5).

FIGURE 4.5 PREVIOUS OCCUPATION



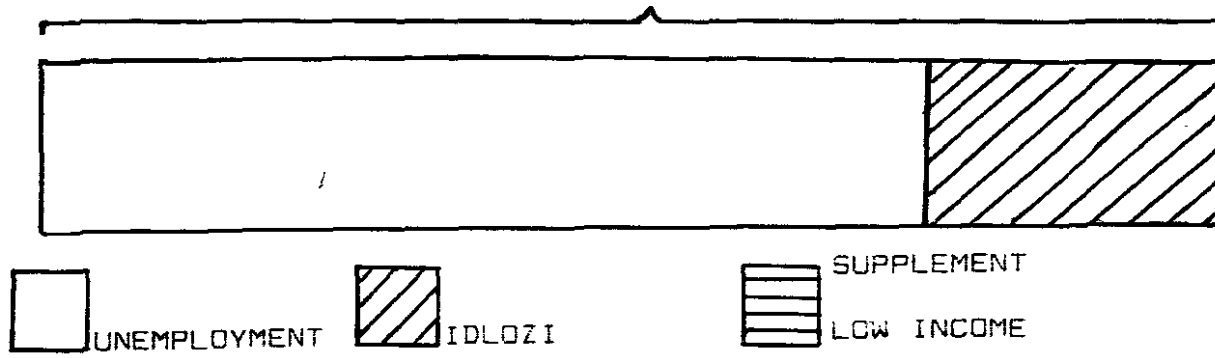
4.3 TRADITIONAL HEALING

4.3.1 REASONS FOR BEING IN THE ACTIVITY

There were various reasons why the healers were engaged in this activity. Twenty seven percent of the healers held that they were called into the activity by ***Idlozi***. Some of the healers were presently employed in industries but they practiced traditional healing in order to get more money to supplement their low wages. These represented 3% of the total number of healers. Seventy percent of the healers were involved in this activity because they

could not find jobs or they lost jobs (Figure 4.6).

FIGURE 4.6 REASONS FOR BEING IN THE ACTIVITY



Some of the traditional healers were engaged full time in this activity and some were part time. Those who were part time included those who were still looking for jobs and those who were involved in order to increase their income. Healers who were full time in this activity totalled to 83%. This showed that the majority of healers had no other sources of income except for this activity.

4.3.2 WORKING HOURS AND DAYS

The number of working hours per day varied greatly. Some of the healers worked for longer hours than others. The majority (77%) worked for more than eight hours per day. Some healers pointed out that working hours depended on the season. In summer

they worked for longer hours since the days were longer. In winter they worked for shorter hours since the days were shorter (Table 4.5).

TABLE 4.5 WORKING HOURS

HOURS	PERCENT
4-6	3
6-8	20
8+	77
TOTAL	100

A total of 60% of healers worked for seven days per week. Some healers worked for less than seven days per week. Thirty-seven percent of the healers worked for between three and four days per week (Table 4.6).

TABLE 4.6 WORKING DAYS

DAYS	PERCENT
3-4	3
5-6	37
7	60
TOTAL	100

4.3.3 RECORD KEEPING

Most of the healers did not keep records of their income and expenditure. Seven percent of the

healers held that they recorded their income only but they did not keep records of expenditure. This was written in an exercise book. None of the healers kept receipts and 93% of them did not have records of any kind (Table 4.7).

TABLE 4.7 RECORD KEEPING

RECORDS	PERCENT
YES	7
NO	93
TOTAL	100

4.3.4 PAYMENT FOR SERVICES

The healers charged different prices for their services. Some would charge lower prices for a service that was expensive at others. The reason for this was that some regarded their medicine as having a better quality than others. In other words, healers did not have a standard price for their services. Another reason for this variation of costs was that some services were very much more important than others and they cost more. Very expensive services included the following:

(i) ***Ukubethela*** (strengthening the home against witchcraft).

(ii) ***Ukuqina*** (strengthening the body against witchcraft and dangerous weapons such as firearms).

(iii) ***Intando*** (to cause somebody to love you for ever).

(iv) **Bhekaminangedwa** (used by females so that her husband may forget other women).

There were three terms of payment used by healers at Umlazi township. All the healers held that they took cash payment from their customers especially when they dealt with simple diseases such as backache, veneral diseases, umeqo, isichitho etc. All the healers registered cash as one of their forms of payment. Ninety percent of the healers used credit for those services that were costly. Only 10% of the healers used cash for all their services. They held that they rarely negotiate credit (Table 4.8).

TABLE 4.8 TERMS OF PAYMENT

TERMS OF PAYMENT	PERCENT
CASH ONLY	10
CASH AND CREDIT	90
TOTAL	100

Whilst the healers used both credit and cash, when it came to selling of medicine, only cash applied. A total of 97% of healers sold medicine. Some sold ready mixed herbs. Others sold unmixed herbs and the customer mixed for himself. Those who did not sell medicine argued that their healing methods were a secret to them. They could not, therefore sell them to other people. They preferred that a patient visit them for help.

4.3.5 TYPE OF CUSTOMERS

Customers came from three groups. Some were from the low income group. These mostly used traditional medicine because they did not have enough cash to pay the medical doctors. They also preferred this type of service for its flexibility in terms of credit. Other customers came from the middle income group and high income group. These used traditional healing for those diseases and services which were not available at the formal medical institutions. These are services related to witchcraft. Also in times of cultural functions e.g. marriage, thanking the customers for providing a good job, twenty-first birthdays (*Umemulo*) etc., these high income groups usually would approach traditional healers.

4.3.6 DISEASES AND SERVICES

Traditional healers were able to treat some of the diseases and offer some types of services. The diseases which were treated ranged from simple to complicated diseases. Simple diseases included veneral diseases, pimples, backache, stomach ache and sores. The complicated diseases included ***Aids, Cardiac failure, Sugar Diabetes, Chest problems, Kidneys, Asthma, High Blood Pressure, Insanity, Stroke.*** The healers were also able to treat the following mysterious diseases. ***Isilwane*** (when there is an animal who kicks family members to death and this animal is invisible).

Intando (a medicine for causing someone to love you).

Ukumusa (to protect a female from miscarriage).

Umendo (to give a woman lucky of getting married).

Ukubethela (to protect a home against witchcraft).

The study showed that 80% of the healers were able to treat veneral diseases. Under these they dealt with diseases such as lice. The other diseases which were commonly treated were pimples and backache. For these they gave a patient vomiting herbs. The least treated disease was aids (Table

4.9).

TABLE 4.9 DISEASES AND SERVICES

DISEASE OR SERVICE		HEALERS %
1.	Aids	3
2.	Cardiac Failure	6
3.	Pimples	15
4.	Veneral Diseases	80
5.	Sugar Diabetes	6
6.	Stomach troubles	14
7.	Chest problems	6
8.	Kidneys	6
9.	Backache	2,5
10.	Asthma	12
11.	H.B.P.	12
12.	Insanity	12
13.	Stroke	1,3
14.	Sores	10

4.3.7 PROBLEMS EXPERIENCED IN THE HEALING ACTIVITY.

The traditional healers at Umlazi township had different problems. One of the most common problems was absconding of customers. As mentioned earlier that healers used both cash and credit, some people

did not return to settle their credits. This posed a very serious problem to healers as it resulted in a shortage of money thus to a shortage of herbs. This problem was experienced by healers at Umlazi. Glebe and kwaMayandu Station (Fig 1.3). Another problem was that of a poor inflow of customers at Umlazi Glebe and lkwaMyandu Station there were many healers concentrated over a small area, this resulted to a very high degree of competititon. Competititon results to another problem because new healers who were still establishing themselves could not compete fairly with famous well established healers (Table 4.9).

TABLE 4.10 PROBLEMS EXPERIENCED BY HEALERS

PROBLEM	PERCENT
Absconding	43
Poor inflow of customers	73
Competition	66

4.3.8 INCORPORATION INTO FORMAL HOSPITAL SERVICES

When asked whether they could agree to serve in hospitals, the healers gave different responses.

Sixty-eight percent agreed and 32% did not agree. Twenty percent of those who agreed maintained that life was very important, therefore they would go anywhere in order to save a life. Some said that they would heal anywhere in order to get money. Those who disagreed had two main reasons. About 60% said that their healing techniques need not be sold to Whites. Forty percent complained that their ways of healing involved things such as vomiting, ukugcaba (cutting flesh in order to apply medicine into the blood) etc. All these things were not easy to do in a busy place like a hospital.

4.4 CONCLUSION

Most of the traditional healers at Umlazi township were males. Most of them were between 30 and 39 years of age. The healers depended on this activity for their living. The number of dependants per healer ranged from one up to seven. Most of the healers, however, had more than six dependants. Most of the healers worked without being assisted by their family members. Most of the healers went to their places of work using public transport such as taxis, trains and buses. Some used private cars but they were very few. Most of the healers did not

reach secondary education. They had received only primary education. Most of the traditional healers had undergone informal training. Working hours varied greatly. The majority of healers worked for seven days per week. Veneral diseases were the most common diseases cured by healers. Healers usually kept no records of their income and expenditure. Most of them used credit as the main term of payment. Besides treating their patients, healers usually sold drugs to other people or to other healers. Customers were from low, medium and high income groups. The main problems encountered by the majority of healers were absconding and competition.

CHAPTER 5

EVALUATION RECOMMENDATION AND CONCLUSION

5.1 INTRODUCTION

Cities are attractive for hundreds of thousands of people in the less developed countries. In these countries people are not only attracted by the possibility of a better living provided by the city, but they are also pushed out of the rural surroundings by factors such as machinization of agriculture. 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 in formal employment. Traditional healing is one such activity. The hypothesis presented will be evaluated in this chapter.

HYPOTHESIS 1

The main reason for engaging in traditional healing activity is the lack of jobs. The study showed that the majority of healers at Umlazi township were once involved in wage earning and others joined this

activity because of unemployment at this time. Those who were once engaged in wage earning lost their jobs and resorted to informal healing, using the knowledge that they collected from their areas of origin. This agrees with what Bryant (1966) observed among the Zulus that the medical profession is hereditary, one of the medicine-man's sons is compulsorily introduced by him in the trade as his assistant during his life and inheriting his legacy of bags and bundles of medicine after his death.

The findings of the study also agrees with the point of view that the informal sector provides the answer to the urban unemployment problem (*International Labour Organization 1972*). This is what happens at Umlazi as traditional healers were not all permanent in this activity but they were waiting for the time when they will be employed. Moser (1984) pointed out that the informal sector functions as a refuge from poverty and an alternative to destitution for those deprived of access to formal employment. The healers at Umlazi were family owners. A total of 50% of healers had more than seven dependants. In order to provide the basic needs for these dependants, they practice informal healing.

Durroux (1970) refers to the people in the informal sector as the "Industrial Reserve Army". Seventy percent of the healers were engaged in the activity because they could not find jobs in the formal sector. The study, however, does not show what Mazumdar (1979) said when he referred to the informal sector as the province of the poor. The reasons given by healers as to why they engaged in this activity included those that are cultural i.e. some healers were invited by their ancestors into the medical profession.

Sarakinsky and Keenan (1986) substantiate this hypothesis when they noted that within South African Black townships and rural Bantustans much of the current rapid expansion of an informal sector is inseparable from the arrested development or even a demise of the formal sector which is not expanding at a sufficnet pace to absorb potential job seekers. Seven percent of the healers were unemployed since they came to the township.

HYPOTHESIS 2

<u>There is easy access to traditional healing activity</u>. The study showed that 40% of the healers

at Umlazi did not have any education. In this way we note that there is no standard of education required for entry into this activity. Healers at Umlazi townships did not have any official permits for practising at their places of business. For their drugs, healers depended on the environment. Therefore capital is not a very important aspect. This is characteristic of the informal sector. Targri (1971) noted that the informal sector entrepeneur does not necessarily need an education and business is done without proper papers. In the informal sector illiterates sometimes have less trouble in finding a job than those having some education.

Santos (1979) held that entry in the informal sector is relatively easy since it is labour intensive. At Umlazi healers did not even need shelter. The majority at Glebe operated in the open air. Some of the healers did not even need transport to go to their places of work. They worked near their places of residence and some worked at their homes. For those who used public transport when going to work only 7% paid more than R70 per month. A total of 73% paid less than R50 per month. This showed that there are no difficulties of entry in traditional

healing at Umlazi. This agrees with what Isaac (1971) noted in Sierra Leone that a small-scale shopkeeper needs only five leons to start a business whilst a large scale shopkeeper needs several thousands of leons to set up a business. A licence to operate a service station requires one million leons.

The healers at Umlazi did not have any expenses of advertising. Their way of advertising is helping more and more people. None of the healers had used newspapers, magazines and television for advertising. This is in line with what Portes (1987) observed in the informal sector activities. He observed that advertising expenditure is almost nil and few entrepeneurs bothered to arrange their windows. One reason for informal advertising might be the fact that most of the healers are illiterate.

Entry into the healing business at Umlazi is easy since the healers need not spend on receipt books and record books. Only 7% of the healers kept records of their income. None of them issued receipts to the customers. This agrees with what Santos (1979) noted at the shanty town of Guyana that none of the informal businessmen kept accounts,

one of them was capable of doing so, and none of them are able to tell with precision what the sales were. At Umlazi none of the healers could tell with precision what their monthly incomes were. Others argued that their income varied from month to month.

There were more than 95% of the healers who did not undergo any formal training. Therefore entry into the healing business at Umlazi does not need a certificate. Uribe (1965) noted that the skills in the informal sector are passed from generation to generation. Some healers learned healing from childhood. Bryant (1966) noted that a person who wanted to be a tracitional healer in the Zulu tribe must undergo a period of initiation. He had to enter the service of the medicine-man as his ***Impakutha*** or ***Uhlaka*** or his assistant. This is how most of the healers at Umlazi were trained and therefore have no certificates.

At Umlazi there are no rules relating to the system of operation or working. The hours and days of business differed greatly. The study showed that 77% of the healers worked for more than 8 hours per day, 20% worked for 6 to 8 hours per day and 3% worked for 4 to 6 hours per day (Table 4.5).

Working days also differed. Some healers worked for the whole week and some worked for less than seven days per week.

HYPOTHESIS 3

A wide range of services if provided by the traditional healers. Traditional healers at Umlazi townships did not only provide services related to the physical health of a person. They cured diseases and also helped in matters related to culture. They cured illnesses such as aids, high blood pressure, stroke etc. Almost all the healers were able to cure veneral diseases of all kinds. They also provided the following services to their customers:

Ukumisa; Ukubethela; Ukudlisa; Umeqo; Isilwane; Udukanezwe; Inhlanhla; Intando; and others.

The other services which they provide were the following:

Strengthening the home against witchcraft and witchdoctors. A medicine that makes a person more dignified and feared by other people. A medicine to

strengthen a person against dangerous weapons such as firearms. A medicine that helps a person who is going for a court case to win it. A medicine that makes a person to keep his money for a longer time without wasting it. Medicine for all types of gambling, winning of competitions etc. A service provided for people who want to be rich (***Ukuthwala***). A medicine that causes people who are planning to kill you to quarrel and reveal their plan to you. A medicine that will cause you to win whenever you fight another person. A medicine to cause your football club to win all the games. A medicine for attracting more and more people to your religious congregaton. A medicine that will give a person senior positions at work. A medicine to cause a thief to bring back your possessions. A medicine for polygamists and so that the wives live in good relations. A medicine for causing women to love you. A medicine for hawkers to have all their goods bought and a medicine to cause your employer to love and trust you more than others.

All these are not provided by the formal healers. There were, however, fewer healers who were able to deal with aids. The healers also sold drugs to other healers or their customers.

HYPOTHESIS 4

The main problem of the healers is that of absconders.

The traditional healers at Umlazi did not keep records of their income and expenditure. They did not issue receipts to their customers. This resulted to problems of absconding. The healers used both cash and credit as terms of payment. Credit is negotiable between the healer and the customer if the services provided are very costly e.g. ***Ukubethela.*** These credits are personal and non-institutional. The healers did not even give a receipt or take the particulars of the customer. When the customer fails to settle his credit, it becomes difficult to trace his whereabouts. Therefore a lot of money is lost through this absconding.

Besides substantiating the hypothesis, traditional healing proved to be part of informal sector at Umlazi. As the countryside has been penetrated by the industrial form of production, the rural-urban difference in wage levels exacerbates the exodus from the countryside to the cities such that Ardant

(1963) speaks of a transfer of poverty from rural areas to the cities. Most of the healers are residents of men's hostels. They left the countryside with a hope of finding jobs in the city. In their failure to find jobs in the formal sector they did not go back to the countryside, they remained in the city and got distributed to different informal activities including traditional healing.

Bernstein (1977) holds that the large number of people struggling to make a living through the informal sector has an affect on intensifying competition between them. This depresses their incomes and standards of living. The healers at Umlazi had a problem of competition. At Umlazi Glebe and kwaMnyandu Station there were many healers concentrated over a small area.

The city provides fewer jobs than the number of those seeking them. Those who are unable to find regular employment called ***Malginals*** (Bernstein and Johnston 1982) consequently swell the ranks of the informal sector forming and increasing the proportion of urban population. This is true of the healers at Umlazi. Their number, according to one

of them, increased instead of decreasing.

5.2 RECOMMENDATIONS

1 The government should recognise traditional healing as one of the necessities for national health care. So as to have uniformity in methods of healing, there should be formal institutions for training traditional healers and there should be an incorporation of traditional healing into formal healing.

2 Health teams should be formed among traditional healers. These would encourage the sharing of knowledge of healing all over the country and organise some seminars now and then.

3 The government of South Africa should make a policy declaration at the top national level to recognise, promote and rehabilitate the traditional system of medicine prevalent in this country and maximise their utilization in health teams particularly in providing primary health care to the population.

4 The government should intensify its efforts at:

(a) inter disciplinary research into the practice of traditional medicine.

(b) the proper training of personnel.

(c) documentation

(d) The conservation and cultivation of medicinal plants.

5 There should be freely available information regarding traditional medicine practices, research findings, flora and fauna and minerals used in the preparation of traditional medicines.

5.3 CONCLUSION

In South Africa there are more than five indigenous groups. All these groups differ slightly in as far as their culture is concerned. It is for this reason that there is a need to let healers of different areas of South Africa to meet and and share their methods of healing.

The informal healing at Umlazi is characterised by ease of entry as it is a labour intensive activity. It is also characterised by reliance on indigenous resources. The healers used the flora and fauna provided by the environment for their herbs and medicine. They acquire their healing skills outside the formal school system. Their working hours are irregular and the prices are negotiable between the

healer and the customer. The relationship with the customers is direct and personal.

Sixty eight percent of healers were in favour of serving in formal medical institutions. This showed that most of the traditional healers at Umlazi are engaged in this activity because they could not find jobs in the formal sector. As they were in the informal business, their incomes were not regular and serving in hospital will mean a guaranteed income per month.

The traditional healers at Umlazi did not undergo any formal training for this activity. Their position is like that of the healers of Thailand where there are no recognised institutions for training traditional healers and they are not made use of by the government for the supply of health care in the country. This position differs from that of countries like India where there are undergraduate and postgraduate institutions for training traditional healers and they are utilised by the government for delivering health services in the country.

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APPENDIX

UNIVERSITY OF ZULULAND

DEPARTMENT OF GEOGRAPHY

TRADITIONAL MEDICINE AT UMLAZI TOWNSHIP

PART A; SOCIO-ECONOMIC CHARACTERISTICS

1. (i)

Age of Subject	
20-29	
30-39	
40-40	
50-59	
60-69	

(ii)

Sex	
Male	
Female	

2. Number of Dependants

None	
1-2	
3-4	
5-6	
7+	

3. (i) Are there any members of your family engaged in informal healing activity?

Yes	
No	

(ii) If any, how many

1-2	
2-3	
3-4	
4-6	
7+	

4. Place of Residence

Umlazi	
Other	

Name

5. (i) Type of Transport used

Bus	
Train	
Taxi	
Private Car	
Walk	

(ii) Cost of Transport per month

Less than R50	
R50-R59	
R60-R69	
R70	

(iii) Approximate Monthly Income

R100-R199	
R200-299	
R300-R399	
R400-R499	
R500-R599	
R600-R699	
R700+	

6. (i) Level of Education

No schooling	
Primary level	
Secondary level	
Tertiary level	

(iii) Type of training

Formal	
Informal	

(iv) Place of Training

7. Previous Occupation

Wage Earning	
Self Employed	
Unemployed	

2. PART B: TRADITIONAL HEALING.

1. What are your reasons for being in the healing

activity?

Unemployment	
Supplementary income	
Interested in the activity	
Other	

(i) Is your engagement part-time (P) or full time (F)

P	
F	

(ii) Number of working hours

Less than 4 per day	
4-6 per day	
6-8 per day	
8+ per day	

(iii) Number of working days

6 days per week	
5 days per week	
4 days per week	
Less than 4 days	

(iv) Places of Activity

Umlazi Station	
Umlazi Glebe	
Mnyandu Station	
Home	

3. What type of diseases do you specialize in?

1.	4.
2.	5.
3.	6.

4. Do you sell medicine?

Yes	
No	

5. How do you advertise your job?

Radio	
Newspapers	
Pamphlets	
Informally	

6. Do you charge a fixed rate for your services?

Yes	
No	

7. Do you keep records of your income and expenditure?

Yes	
No	

8. What are your terms of payment?

Cash	
Credit	
Negotiable	

3. PART C: GENERAL.

1. What problems do you experience in this activity?

Confiscation of drugs	
Fines	
Prosecution	
Poor invlow of customers	
Overcrowding	
Absconding	
Competition	

2. Are your customers mainly from

Low income group?	
Middle income group?	
High income group?	

3. (i) Do you support the employment of traditional healers in formal Medical Institutions?

Yes	
No	

(ii) Reasons for both _____

_____

4. What are your future plans?

Searching for a job	
Continue with Traditional Healing	
Supplying drugs to small healers	
Opening a training centre for healers	
Formalization of your activity	