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The role of traditional health practitioners in health promotion: A case study of the Pfura Rural District, Mashonaland Central Province, Zimbabwe.

by

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Declaration

I, **Mambanga Pfungwa,** do hereby solemnly declare that this thesis for Doctor of Philosophy in African Studies at the University of Venda titled **“The role of traditional health practitioners in health promotion: A case study of the Pfura rural district, Mashonaland Central Province, Zimbabwe**”, hereby submitted by me has not been previously submitted for any degree at this or any other institution, and reference material contained herein has been properly acknowledged.

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Abstract

Traditional health practice is an important and often underestimated part of health care. Since time immemorial traditional health ensured and covered all major areas of health promotion, which included preventative, promotive, curative, rehabilitative, and surgical practices. In low- and middle-income countries where the number of practitioners of modern medicine may not be enough to meet the health care needs of the country, traditional health promotion is central. Given that in many societies the practices are done in secret, it therefore makes it difficult for people in general to access proper service from traditional health practitioners. This study explored the role of traditional health practitioners in promoting health in a rural community. The study adopted a qualitative approach which was descriptive, explorative and interpretative, targeting the registered traditional health practitioners in villages of Ward **X** of the Pfura Rural District Council. A non-probability purposive and snowball sampling method was used to identify twenty-two (22) male and female participants. The participants were registered diviners, herbalists and traditional birth attendants. The data which was collected through in-depth interviews, field notes, audio recordings and observation were thematically analyzed using Tesch's method of data analysis and presented in categories, themes and subthemes. The study revealed that the traditional health practitioners in Pfura, are playing a vital role in offering primary health care for the people. Traditional health practitioners offer healing through their extensive knowledge of herbal and animal-based medicines and therapeutic actions such as rituals. The study established the use of herbs, traditional ceremonies, taboos, cultural norms as health promotive practices. Traditional healers in Pfura have demonstrated their efficacy and remained a powerful establishment in society through their easy access to the ancestral spirits, which has sustained the healing culture of Kore-kore people. Despite the central role being played by traditional health system in health promotion, impediments were found against the practice and its practitioners. Poor professional development, research and training of the Traditional Health Practitioners as well as the advanced age of practitioners is a setback in the practice as it contributed negatively to the sustainability of the traditional health practice. Guided by both study findings, key action areas of health promotion of the Ottawa Charter and the objectives of the World Health Organization, Traditional Medicine Strategy of 2014-2023 target, a framework/guide was developed and recommended an integrative and sustainable health promotion in a rural setting.

Key words: traditional, indigenous, knowledge, rural, health promotion, Pfura Rural District

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Thanks also to my lovely wife, Lisa Wadzanai Kashiri, for her support and assistance.

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Dedication

This study is dedicated to all specialized public health educators and promoters in the world, and to my mother, Nancy Sazunza, who always wants me to be the best I can.

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List of Abbreviations and Acronyms

AIDS	Acquired Immune Deficiency Syndrome
HIV	Human Immune Virus
HP	Health Promotion
IHPPs	Indigenous Health Promotion Practitioners
IK	Indigenous Knowledge
IKSs	Indigenous Knowledge Systems
PHC	Primary Health Care
RDC	Rural District Council
THP	Traditional Health Promotion
THPs	Traditional Health Practitioner's
TM	Traditional Medicine
TMPC	Traditional Medical Practitioners Council
TBAs	Traditional Birth Attendants
THP	Traditional Health Practitioner
THPP	Traditional Health Promotion Practice
TM	Traditional Medicine
WHO	World Health Organization

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WHO TM	World Health Organization Traditional Medicine
ZINATHA	Zimbabwe National Traditional Healers Association

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CHAPTER ONE

STUDY OVERVIEW

1.1. Introduction and Background to the study

The 19th century marked the establishment of Christianity and colonialism on the African continent. Christianity ridiculed and undermined African traditional practices which included traditional health promotion. The colonial government of Southern Rhodesia, now Zimbabwe, prohibited traditional African medicine, a practice that had been an integral part of the culture of the people of its land for generations (Chingwaru & Vidmar, 2016). Zimbabwe got its independence from Britain in 1980. It inherited a colonial health care system which was divided along racial lines which was characterized by imbalances in the distribution of physical, financial, and human resources (Buzuzi, Chandiwana, Munyati, Chirwa, Mashange, Chandiwana, Fustukian, & McPake, 2016).

However, the postcolonial (post-1980 era) Zimbabwean government then took steps to revive and recognize African traditional health practices. In 1981, the Government of Zimbabwe passed the Traditional Medical Practitioners Act which recognized the Zimbabwe National Traditional Healers Associations (ZINATHA). This association of traditional healers was formed in July of 1980 (Buzuzi et al., 2016). The Zimbabwe government made progressive commitment to correct the imbalances and pursuing equity to address the then existing inequalities particularly in the rural settings. However, the progress made between 1980 up to the late 1990s, was suddenly shaken by the economic disintegration which occurred between 1997 and 2009.

During the first five years of the 21st century (2000-2005), the Zimbabwean health care delivery system experienced a total breakdown due to the economic and political crisis that severely affected the whole country. Zimbabwe experienced serious political violence before, during and after the national election of year 2002. At the same time, a cholera outbreak claimed dozens of people’s lives (Mengel, Delrieu, Heyerdahl, & Gessner, 2014). The health care burden was worsened by a drought which resulted in food shortages and triggered many non-communicable diseases. The breakdown of the health care system has been further deepened by the humanitarian crises which spanned between 2008 and 2010 which has resulted in poor maternal

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and child health services and consistently falling but nevertheless still-high numbers of people living with HIV (Maponga, Chirundu, Gombe, Tshimanga, Bangure & Takundwa, 2015).

The country saw a high infant mortality rate, a high morbidity rate, and a high death rate and eventually the life expectancy declined. In March 2003, Zimbabwe was put under economic sanctions called ZIDERA – Zimbabwe Democracy & Ecomomic Recovery Act of 2000 from the Western countries (Nzaro, Njanike & Munenerwa, 2011). This brought industrial productivity to a halt. The hyperinflation which rocked the country at that time resulted in the shortage of drugs in public hospitals, thus primary health care principles were compromised. The country's health sector faced many challenges which included a shortage of skilled professionals and health-care staff, an eroded infrastructure with ill-equipped hospitals, and a lack of essential medicines and commodities.

Due to the challenges experienced in accessing health services during the time of Zimbabwe's economic collapse, the mass, particularly the rural folk, resorted to indigenous knowledge systems (IKS) based traditional health promotion. This was an observation highlighted by Buzuzi et al., (2016). Traditional health practices were used because of their affordability, availability, accessibility, and cultural appeal. For a long time, traditional health practices have served as a major socio-cultural heritage and resource for African people despite Western beliefs and religions which regarded them as primitive. Mposhi, Manyeruke & Hamauswa (2013) argue that from 2002 to present, traditional health practices have become the back bone of Zimbabwe's primary health care system. About 80% of the country's population rely on traditional health therapies for health promotion for all.

The Ottawa Charter of 1986 defined health promotion as a process of enabling people to increase control over, and to improve, their health (Naido & Wills, 2016). Health promotion practices as enshrined in the Ottawa Charter cover not only the primitive curative aspect but it includes preventative, promotive, rehabilitative, and surgical aspect. Health promotion is therefore being traced as a major force to the 1984 publication of the WHO discussion document on the concept and principles of public health which emerged during the Alma Ata declaration of 1978. Chenoweth, (2018) further reiterated that, contemporary health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being. In the same vain, health promotion is regarded as central and backbone of public health as it tells that health

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is not only determined by investment in the health sector alone but must consider the impact of the wider societal determinants such as culture, religion, and economics (Deehan & Wylie, 2016).

Most medical doctors in Africa are concentrated in urban areas and cities (Grobler, Marais & Mabunda, 2015). Therefore, for millions of people in rural areas, traditional healers stay their health providers. Scholars confirm that the move from conventional practice to traditional health practices in Zimbabwe was not a necessity but was circumstantial (Bhebhe et al., 2016). It is well documented that before the onset of the Zimbabwean health crisis the rural populace used both conventional and traditional health practices. However, due to the collapse of the Western oriented healthcare system, rural people were left with no choice but to resort to the traditional health care system.

Traditional health promotion practices based on indigenous knowledge have always existed in most cultures. In the modern era, Ayurveda, Unani, Shamanism, Chinese, African traditional healing practices, and many others are re-emerging in rural areas and cities and are being practiced alongside contemporary Western forms of healthcare (Fry & Zask, 2016). The modern development of health promotion also shows that there is a need to include local people, their traditions, and practices in promoting health.

Moreover, given the high percentage of people who rely on traditional health practitioners, it is crucial to expose the health promotion practices for sustainable and quality health care delivery in the traditional health system (Kemppainen, Tossavainen & Turunen, 2013). The foregoing observations make it imperative to investigate and explore the role of traditional practitioners in the traditional health promotion.

1.2. Problem Statement

Chingwaru and Vidmar (2016) point out that the traditional health practitioners' role in health promotion is not well documented given that in many societies most of the practices are done in secret. It therefore makes it difficult for people in general to access proper service from traditional health practitioners. Apart from usage, given its secretive nature, the traditional health practice has been immune to public opinion specifically for improvement and strengthening purposes. Given the wider quotation that suggest that 80 % of world population particularly low to middle income countries relies on traditional health promotion which incorporates the healing power of

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plants and herbs notably in the absence of a functioning health care system (Yuan et al., 2016), few known scientific studies have been done in Zimbabwe to ascertain this level of usage (80 percent). Furthermore, in these few studies conducted, their focus have been on clinical efficacy of traditional medicine while neglecting the roles of traditional practitioners in health promotion. It is against this ailing background of knowledge paucity, economic meltdown, a crushing health care system, the secretive nature of traditional health, that made it imperative for this study to explore deeper into the roles of traditional health practitioners in promoting health of the rural folk.

1.2 Purpose of the study

The aim of the study was to explore the role of traditional health practitioners in promoting health in the Pfura Rural District.

1.2.1 Research objectives

- To document the profile of traditional health practitioners in the Pfura Rural District.
- To document indigenous health promotion practices of traditional health practitioners in the Pfura Rural District.
- To investigate the challenges faced by traditional health practitioners in promoting health delivery in the Pfura Rural District.
- To identify strategies for enhancing and sustaining traditional health promotion practices in a rural setting.
- To develop a framework/guide for a sustainable and integrative health promotion in a rural setting.

1.2.2 Research questions

The following questions guided the study:

- What is the profile of traditional health practitioners in the Pfura Rural District?
- What are the indigenous health promotion practices in the Pfura Rural District?
- What are the challenges facing traditional health practitioners in promoting health in a rural setting of the Pfura Rural District?

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- What are the strategies to enhance and sustain traditional health promotion practices in a rural setting?
- What constitute a framework/guide for enhancing and sustainable traditional health promotion in a rural setting?

1.3 Significance of the study

Given the paucity of published material on this subject, this study aimed at contributing to the body of knowledge on the aspect of traditional health practitioners' roles in health promotion, particularly in the rural health care setting. This study attempts to rectify this problem by giving current evidence about the role of traditional health practitioners in promoting health. It is hoped that this study would strengthen the goal of the "Health for All" mantra as proposed by the World Health Organization in its goal of primary health care delivery. The knowledge generated through this research would add to the existing knowledge of nursing care with regards to cultural diversity in nursing care delivery as well as the incorporation of traditional health care. If these findings are published about the role of traditional health practitioners as health promoters it will enable reach to wider audiences and consumers.

Additionally, a great proportion of the available research was conducted more on the herbalism, efficacy and use, thus the current situation of promoting health in general is largely unknown (James et al., 2018). The findings of this study stand to be useful to stakeholders such as the Zimbabwe Ministry of Health and other health stakeholders in the world in general to develop and implement national and institutional policies and guidelines about the role of traditional health practitioners and their use of indigenous knowledge in health promotion. The traditional health practitioners will also get insights into the dynamic challenges that affect their practice therefore it will be a cornerstone for the improvement of rural health promotion. People in the rural areas and traditional healthcare service providers are expected to receive help from the findings about how best health can be promoted through the IKSs leading to its preservation.

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1.4 Definition of key concepts

1.4.1. Indigenous Knowledge (IK)

(IK) is used synonymously with traditional and local knowledge to differentiate the knowledge developed by and within distinctive indigenous communities from the international knowledge systems generated through universities, government research centers and private industry, sometimes incorrectly called the Western Knowledge System (Mawere, 2013). Ford et al., (2016) attested that traditional knowledge includes the know-how, skills, innovations, practices and learning that form part of traditional knowledge systems, and knowledge that is embodied in the traditional lifestyle of a community or people, or is contained in codified knowledge systems passed between generations. The Institute goes on to suggest that the concept incorporates indigenous knowledge, traditional ecological knowledge, intangible cultural heritage, traditional medicine and traditional cultural expressions. For the purposes of this study, the Indigenous Knowledge (IK) refers to the medicinal information, practices, skills, and performances which were gained traditionally through oral tradition.

1.4.2. Health promotion

Health Promotion is the art and science of helping people discover the synergies between their core passions and best health, enhancing their motivation to strive for best health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be eased through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice (Donnel, 2009). In this study, health promotion is regarded as collective activities of traditional health practitioners and the community that enhance public health and best health for all in a rural setting.

1.4.3. Traditional medicine

Traditional medicine is defined in the Traditional Health Practitioners Act of South Africa (Act 35 of 2007) as an object or substance used in traditional health practice for the diagnosis, treatment, or prevention of a physical or mental illness, or any curative or therapeutic purpose including the maintenance or restoration of physical or mental health or well-being in human beings, but does

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not include a dependence-producing or dangerous substance or drug. According to WHO (1996) Traditional medicine refers to ways of protecting and restoring health that existed before the arrival of modern medicine which started to promote such methods in the 1970s. The promotion has centered largely on developing non-Western. In this study, traditional medicine includes practices for curing and prevention of diseases such as the use of traditional herbs, animal products traditional foods intake and other traditional and spiritual practices aimed at health promotion.

1.4.4. Traditional health practitioner (THP)

Traditional health practitioners (THP) are variously known as practitioners of ethno-medicine, folk medicine, native healing, or complementary and alternative medical practitioners. This form of health care system has stood the test of time. They use an ancient and culture-bound method of healing that humans have used to cope and deal with various diseases that have threatened their existence and survival (Abdullahi, 2011). In this study, THP are individuals (diviners, herbalists, and traditional birth attendants.) who present knowledge, skills and practices based on the beliefs and experiences of different cultures, whether explicable or not, used in the maintenance of health, as well as in the prevention, diagnosis, improvement, or treatment of physical and mental illnesses.

1.4.4.1. Diviner

A diviner is an individual who has the power to deal with the spiritual realm. They look for disturbing events in the past, which can cause misfortune if left untreated (Zuma et al., 2016). Many diviners are specialized in one or more biomedical aspects, such as herbalism, midwifery, or surgery. In this study diviners are the individuals who use the power of dreams and interpretation of the unknown world, clairvoyance, and oracle consultation together with the use of divination objects like bones and beads.

1.4.4.2. Herbalist

A herbalist is an individual who heals common ailments, such as headaches or coughs which are considered to be diseases with natural causes. Herbal medicines are applied to every part of the body in any conceivable way. There are oral forms, enemas, fumes to be inhaled, vaginal preparations, fluids administered into the urinary tract, preparations for the skin and various

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lotions and drops for the eye, ear, and nose (Anderson, 2018). In this study, the herbalists are men and women who identify, process and administer plant and animal products for healing, preventative and protective purposes.

1.4.5 Traditional health promotion practices

WHO (2014) defines traditional health promotion practices as a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system. This study regards traditional health promotion practices as any act by indigenous people which is undertaken to improve the health of people. These practices are curative, preventative, promotive, surgical, and rehabilitative.

1.5 Chapters Outline

The outline of the thesis and the various aspects that are presented in each chapter is presented below:

Chapter 2: Conceptual framework of the study

Assumptions and beliefs that support and inform the study are reviewed and presented.

Chapter 3: Literature review

Data based and theoretical based information is reviewed in areas of traditional health practices and challenges to the traditional health promotion in a global, regional, national, and local approach.

Chapter 4: Research Methodology

The study design and approach is presented and the aspects of the entire method which include sampling, population, data collection, analysis, ensuring trustworthiness and ethical consideration

Chapter 5: Results presentation and interpretation

In this chapter the study findings are presented and interpreted as per study aims.

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Chapter 6: Discussion of the study findings

The study findings are discussed in relation to other study contacted in similar and contrasting settings to drive its meaning and identification of gaps.

Chapter 7: Conclusion and Recommendations.

A conclusion to the study, and recommendations are drawn from the findings and presented on this chapter.

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CHAPTER TWO

2: THEORETICAL FRAMEWORK OF THE STUDY

2.1 Introduction

"What we see as science, the Indians see as magic. What we see as magic, they see as science. I don't find this a hopeless contradiction. If we can appreciate each other's views, we can see the whole picture more clearly. To heal ourselves or to help heal others, we need to reconnect magic and science, our right and left brains" (Hammerschlag, 2011).

Promoting health and preventing disease is a noble goal that, to many, might seem straightforward, logical, and highly scientific. Many people have known about germ theory, disease of lifestyle, medications, radiation, surgery, and other Western approaches to preventing and/or diagnosing and treating health problems in the general population. What Hammerschlag (2011) is pointing out, however, is that this process is not always what it seems. Indeed, there are many ways of perceiving, understanding, and approaching health and disease processes across cultural and ethnic groups with which health practitioners need to become better acquainted.

2.2. Afro-centricity: The Theory of Social Change.

WaThiong'o says "Remembering Africa is the only way of ensuring Africa's own full rebirth from the ages into which it was plunged by the European renaissance, Enlightens and modernity (Adeoti, 2016)."

Afrocentricity is a frame of reference wherein phenomena are viewed from the perspective of the African person and it is also a mode of thought and action in which the centrality of African interests, values, and perspectives predominate (Hatcher, King, Barnett & Burley, 2017). Afrocentricity materialized as a theory of knowledge in 1980 under Molefi Kete Asante's philosophical thinking while also posing a systematic challenge to Western epistemology. However, is an idea which emerged in the African American cultural panorama as a set of premises that would account for the understanding of an African sense of totality and wholeness in a network of multiple and particular manifestations of different fields of knowledge to address the life and experience of people of African descent in America, in the African continent, and in other diasporas (Asante, 2017). Asante's theory of social change was primarily addressed to a

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detailed investigation and questioning of the Eurocentric nature of knowledge to avoid personal and collective destruction of people of African descent and to reclaiming an African cultural system as the coherent meeting point of every African cultural and historical past. Afrocentricity theory further seeks ways of unity based on mutual respect for the cultural agency of all people. Asante states, "the Afrocentric idea is projected as a model for intercultural agency in which pluralism exists without hierarchy and respect for cultural origins, achievements, and prospects is freely granted (Verharen, 2000). This brings in the essence of using indigenous knowledge systems as an important resource for Africans to achieve developmental freedom in all facets of life particularly health promotion.

Afrocentrism believes that culture is the most powerful influence on health, social, political, educational, economic, and religious structures. Historically, Africans have been known to have deep ties to their cultural heritage, including religious traditions and ideologies handed down from prior generations. However, since the colonial invasions, African indigenous knowledge has experienced rapid change particularly in health, economy, and politics (Schiele, 2017). Afro-centricity, as a feature of Pan-Africanism presents Africa with a remedy to the effects of Euro-centrism. Therefore, it is time Africans recognize the importance of viewing issues from the African perspective to reap the full benefits that Afro-centricity offers. In this regard, it can be argued that the African world sense, cosmogonies, institutions, concepts, symbols, and voices can only be fully perceived and appreciated through a holistic paradigm like Afrocentricity.

In this study, the Afrocentricity approach is discussed in relation to health and indigenous knowledge system wherein it calls and emphasizes the African people to own their means of health promotion practices which claim their identity and promote African renaissance and Africanization. Louw (2000) labels it as a shift in the consciousness of the individual to re - establish our diverse traditional African values, so as to embrace the individual's responsibility to the community and the fact that he/ she in community with others together are in charge of their own destiny.

Renaissance and idea that embrace and support the Afrocentricity approach, implies that there is need for the people to rethink their past. In support of the same view, Josse (2009) suggests African Renaissance can be looked at in two parts, African and Renaissance within the main concept of African renaissance. The term African has been used to define those things that are indigenous to Africa. Terms such as traditional African values and return to aspects of Africa's

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indigenous civilization imply that there are such things as traditional values and indigenous civilizations that are unique to Africa. Clarke (2014) propounded the view that Afrocentricity refers to a perspective that involves finding people within the context of their own cultural references so that they can relate to the importance of indigenous knowledge as a resource to African development. From the above, the concept advocates for total freedom and it recognizes Africans as people who can do for themselves as contrary to what Europeans say, "Africans, cannot do without the help of Europeans". The theory reveres the indigenous African's point of view hence it castigates the treatment of Africa as 'the other'.

Afrocentrism, which means African centeredness, does not violently confront any person or people, but is a resolute attempt to put the records right and it is about placing African people within their own historical framework (Asante, 2017). Afrocentricity in indigenous health therefore instructs us when pursuing or articulating knowledge of (or about) African peoples, to always center (our perspectives on norms drawn from the African cultural system of traditional health. In support of the indigenous health practices, the idea of Afrocentrism is said to be an idea that African group ought to reassert a new way of looking at information from a black perspective (Chinweizu, 2010). It therefore proposes that Africans must examine knowledge and use it from an African perspective, suggesting that health promotion practices are to be done from an African standpoint.

Asante (2014) also states that, "Afro-centricity is an intellectual paradigm that privileges the centricity of Africans within the context of their own historical experiences". It seeks to challenge Euro-centric viewpoints and its domination on African people because of the slave trade and colonialism. Euro-centrism presents a racist, divisive, ahistorical, and dysfunctional view of world history. The Afro-centrist asks the question, 'What would African people do if there were no white people?' Afro-centricity, therefore, answers this question by asserting the central role of the African within the context of African history, thereby removing Europe from the African reality" (Asante & Mazama, 2009). This therefore calls for Africans to show their innovation prowess through doing, seeing and thinking about their future through the African lens. Africans should define their destiny thought he use if IKS. In health promotion, this question has been answered since time immemorial, given the long-life span of traditional healing. Traditional healing has been there since the creation of mankind, now its calling for revival for sustainability given the high percentage of people using traditional medicine.

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Afrocentricity further contends that our main problem as African people is our usually unconscious adoption of the Western worldview which results in African people abandoning their own practices which are based on the local indigenous knowledge (Schiele, 2017). This sentiment can be viewed in the context of the era of African colonization wherein many traditional health practices vanished from the health fraternity as they were labeled primitive and heathen by the advent of colonialism and Christianity. Moreover, African health practices were viewed as inferior to Western practices hence they lost popularity.

The use of indigenous knowledge in health promotion is fundamentally linked to the African Renaissance or nation building and the issue of reclaiming an African identity (Afrocentricity). Furthermore, to the achievement of African identity, theorists suggest that indigenous people need to regain confidence in their own capabilities, given the dilapidating economies of Africa particularly Zimbabwe, traditional health system is the answer given its affordability, availability, and its appealing nature to the culture. This therefore gives contrary view to the entrenched feeling of inferiority inflicted during the years of colonialism and apartheid wherein traditional health was condemned to be heathen and evil (Hatcher et al., 2017).

Afrocentricity therefore implies that knowledge and technologies around communities which are indigenous to a geographical area should be explored with a view to contribute to local development. Despite the adverse effects of colonization on IKS, most African countries have managed to find themselves in the health system against all economic crises. In Uganda, for example, studies revealed that traditional knowledge in the health care system of maternal care was successfully used to combat high maternal mortality rates well-known and trusted system to aid mothers and babies during labour, without the use of conventional methods (Miike, 2017).

2.3. CONCEPTUAL FRAMEWORK OF THE STUDY

2.3.1. Introduction

Adom, Hussein and Agyem (2018) defined a conceptual framework as a structure which the researcher believes can best explain the natural progression of the phenomenon to be studied and it is the researcher's explanation of how the research problem would be explored. A conceptual frame work is arranged in a logical structure to offer a picture or visual display of how ideas in a study relate to one another (Grant & Osanloo, 2014). The conceptual framework offers

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many benefits to a research such as assistance in identifying and constructing his/her worldview on the phenomenon to be investigated (Akintoye, 2015). The notion behind citing and discussing the concepts underpinning the present study was to gain deeper understanding and to gather sound and validated arguments. This interdisciplinary study combines two aspects which are indigenous knowledge systems and health promotion from an African perspective.

Mumm et al., (2017) see that the multidisciplinary approach for a single study gives good general knowledge breadth, as well as depth of knowledge which gives researchers connections between ideas and concepts across different disciplinary boundaries thus deepening learning and improving conformability. Many ideas have been postulated in the subject of traditional health and indigenous knowledge systems and explanations have been done to express the link between the two. This study therefore presents ethnomedicine, a concept that define health beliefs from a cultural and ethnicity point of view.

In these study this concept gives an insight on how African people view health and promote health with much attention given to the rural folks who are presently the custodians of indigenous health practices in communities, particularity of the Zimbabwean people. Ethnomedicine become more important to this study since illness and the need to treat the sick are common to human societies, however, many factors influence the experiences of health and illness. These factors include natural environment, genetic inheritance, and above all socio-cultural and economic circumstances interact with one another, in complex ways, to influence the health of any human population (Quinlan, 2011). Therefore, how societies view health and the therapeutic techniques to treat illness vary considerably from one society to another.

2.4. Ethnomedicinal approach

Ethnomedicine, according to Quinlan, (2011) is a concept borrowed from cultural theories which examine and translates health related knowledge and theories that people inherit and learn by living in a culture. Levinson (1997) elaborated the three components of medical systems common to every culture in such a way that every health care system is assumed to share common elements such as the definitions of health and illness, the beliefs (theories) about the causes of illness, treatment strategies, the healers, specific methods and techniques of treatment, and a decision-making process for using the health care system. Giovanni (2015) attested that

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ethnomedical approach focuses on the medical care's system from the natives' point of view which includes the practices by various ethnic groups.

Ethnomedicine defines the way human groups handle disease and illness considering their cultural perspective. Ethnomedicine embraces two important aspects of a health care system which include the indigenous conceptualization of diseases (traditional beliefs about the nature and cause of disease) and the health care delivery (prevention, protection, and cure). The ethnomedicine examines and translates health related knowledge and theories that people inherit and by living in a culture, therefore each society has a medical culture (Caneva et al., 2017). The ethnomedical approach forms a great pillar for this discourse as it will define the African, particularly Zimbabwean medical culture. The present study therefore looked into the medical culture of Kore-Kore people of Zimbabwe as it is practiced by the registered practitioners for the betterment of rural public health.

Apart from looking only at the symptoms, the African traditional health practice explores what unfolds at the deeper levels of situations and how the situations could have been prevented or could now be handled. In Zimbabwe, there is a Shona proverb which says, *"Pane chauraya zizi, harifi nemhepo",* which means something has killed the owl, it cannot just be the wind (Bhebhe, 2014). In an African perspective this means that, apart from the observable signs, there are always some underlying and unforeseen causes of disease and misfortune which need to be attended to. The traditional health practitioners therefore use their medical culture in the instances of an illness whereby an exploration of the sociological, spiritual, and psychological situations is done to see what might be the cause of the physical suffering, thus providing an integrated approach to health promotion. The exploration process includes the interpretation of dreams, clairvoyance, and performance of rituals with the communication with the ancestral spirits which is believed to handle the super natural world.

Addy (2017) explains that traditional health practice in Africa is a holistic one that integrates our social ethics, religious morals, and cultural values. Ethnomedicine believes that the health of an individual has a link with the metaphysical and supernatural world, with the creator, divinities, and ancestral spirits. It is out of this belief that disease has a spiritual dimension. Despite the scientific theories of disease which are valid, it is therefore not surprising that in the traditional health care system of Zimbabwe, we find practices relating to the use of herbs and other natural products in addition to the use of spiritual and psychic powers for the treatment of diseases.

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The anthropologists regard a culture as a symbolic system, a people's view of health and illness is part of that system and therefore any disease is part of the cultural construct (Kennedy & Gittelsohn, 2015). The adoption of the ethnomedical approach in this discourse is to get a deeper understanding on how a rural people with specificity to a Zimbabwean group of people perceive and deal with health and disease in an African traditional perspective. This approach embraces the study of health beliefs, healing techniques and traditional practitioners as phenomena related to the culture and society in which they are found. An ethnomedical approach illuminates how a society's culture creates specific problem solving mechanisms involving health, illness, and traditional health practice (Giovannini, 2015).

The ethnomedical approach amplifies the importance of understanding the various paradigms of disease and health care which are bound to culture, social construction and at least in part, to their worldview. The ethnomedical model therefore gave a framework on which to explore the use of indigenous knowledge and comprehensive approach by traditional health practitioners in health promotion for primary health care (Gruca et al., 2015). In the present study, the ethnomedicine approach aids the researcher in understanding the cultural interpretations of health, and the documentation of traditional healing practices. In an African context and Zimbabwe being an example, the diseases or an ailment (for example, mental illness) is viewed as a curse from the Gods/ancestors therefore their approach to health promotion is embedded in the same belief. The traditional medicine is therefore used through the instruction of the spirits who protect the given tribe. Pushpangadan et al., (2017) add that, unlike the modern health system, in this instance, the healing process is that the patient will go ritualism, cleansing and exorcism depending on what the traditional healer's spirit says.

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CHAPTER 3

LITERATURE REVIEW

3.1. Introduction

The typical purpose for analyzing and reviewing existing literature is to generate research questions to identify what is known and not known about a topic and to identify concepts of the theoretical traditions within the bodies of literature, and to describe methods of enquiry used in earlier work including their success and shortcomings. However, given the broadness of the aspect of IKS, this review of literature will specifically draw attention to various published information and sources of literature, with specific focus on IKS and Indigenous Health Promotion.

Health promotion was defined initially by the World Health Organization in 1986, but the definition has since been refined to take account of new health challenges and a better understanding of the economic, environmental and social determinants of health and disease. As quoted in Aligood (2014), Nola Pender defines health promotion as the process of enabling people to increase control over, and to improve their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions. Health promotion describes behaviors an individual can perform to bring greater longevity and a high quality of life. Health promotion can bring about a sense of wellbeing and harmony to the individual, can increase energy, and can also decrease social problems. Nola Pender as one of the first theorists of health promotion argued that HP is probably the most ethical, effective, efficient and sustainable approach to achieving good health (Cragg, 2013).

3.2. World view on IKS and Health Promotion

Around the world there is an extensive use of traditional medicine, which is composed of medicinal plants that have been argued to be linked to cultural and economic reasons. This gives a reason of why over a long period the World Health Organization (WHO) encourages African member states to promote and integrate traditional medical practices in their health systems (WHO, 1978). It is argued that in all countries in the world there exists traditional knowledge related to the health of the indigenous people of different ethnic groups. Despite the abundance of effective modern treatments, the utilization of traditional medicine is prevalent world-wide. Cross-sectional studies conducted in Turkey, the United States of America, Malaysia, and Australia estimated the

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prevalence of traditional medicine (TM) use as 61%, 82%, 61%, and 51% respectively (Kurande, Waagepetersen, Toft & Prasad, 2013).

Around the globe, patients have resorted to TM in every disease entity and illness and in all forms and composition. People, especially the rural folk, have used TM as the sole treatment while others combined it with a prescribed modern therapy. Traditional Medicine has been used for treatment or preventive modality, for acute or chronic purpose, psychiatric disorders, and for benign or malignant disorders. Treatment of various ailments using traditional medicines has emerged as the most significant health care alternative to modern medical practices around the globe.

Vlietinck, Pieters, Apers, Cimanga, Mesia, and Tona (2015) state that, the ancient population relied on useful therapeutic agents in the plant and animal kingdoms when confronted with illness and diseases. The empirical traditional knowledge of these medicinal substances and their toxic potential was passed on by oral tradition and sometimes recorded in herbal books. It is argued that many valuable drugs of today, for example morphine, digoxin, quinine, tubocurarine and many others, came into use through the study of indigenous remedies (Kazembe, Charumbira & Munyarari, 2012). According to the World Health Organization, up to 80% of the world's population depend on traditional medicine for primary health needs (Shetty, 2010).

In many countries of in Africa, South America and Asia where modern healthcare is not readily available or affordable, the public continues to rely on traditional medicines which are based on locally available natural resources. Some globally known forms of traditional medicine include traditional Chinese medicine, Tibetan traditional medicine, Ayurvedic medicine (which has origins in ancient Indian society), Thai traditional medicine (Kingdom of Thailand) and traditional African medicine (Mengel et al., 2014). Despite the world-wide improvement of health over the past four decades, in every region the health status of the rural populace has been left behind as compared to their affluent counterparts, thus the need for fusing and promoting IK in health care systems arises. A brief and general overview of some major traditional medicines of the world is discussed in below.

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3.2.1. Chinese Traditional medicine

The Chinese traditional medicine is inseparably linked to Chinese cosmology as system of beliefs that can be summed up as all of creation is born from the marriage of two polar principles: yin and yang (Yuan et al., 2015). It further outlines the examples as earth and heaven, winter and summer, night and day, cold and hot, wet and dry, inner and outer, body and mind. These pairs of opposites are connected via a circular harmony. The yin and yang symbol is helpful in representing this concept. Harmony means health, good weather, and good fortune, while disharmony leads to disease, disaster, and bad luck. The strategy of Chinese medicine is to restore harmony, as each human is thought of as a world in miniature, and every person has a unique terrain to be mapped, a resilient yet sensitive ecology to be maintained. Like a gardener who uses irrigation and compost to grow robust plants, the doctor uses acupuncture, herbs and food to recover and sustain health and herbal medicine is an important part of Traditional Chinese Medicine (Yang et al., 2017).

Herbs are prescribed holistically, according to the patient's individual condition (not only on the basis of current symptoms). Herbal medicines are used to regulate the natural balance of the body and restore health which come in the form of pills, powders, tinctures, and raw herbs taken internally or as balms for external use (Maciocia, 2015). Chinese herbal medicine has been used for centuries to treat most health conditions, and as a preventative dietary supplement, and has been used safely in conjunction with many western therapies (Yuan, Ma & Piao, 2016). The diagnosis is made by talking to the patient, looking at physical characteristics and employing the ancient arts of tongue and pulse diagnosis.

3.2.2. Japanese Traditional Medicine

Kampo is a Japanese herbal medicine, which has a long history of clinical application; it uses precisely measured herbs to treat illness, based on the skillful use of well-known formulas, valued for their impact on clear as well as vague conditions (Frank et al., 2016). Kampo does not only use rare or endangered plant or animal products. The distinguishing feature of Kampo is its method of diagnosis through abdominal palpation and it is based on the theory that diseases arise because of a disharmony in the flow of Qi (Chi)/energy. By stressing prevention, Kampo helps the patient to maintain good health according to natural principles.

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3.2.3 Traditional Vietnamese Medicine (TVM)

The distinguishing feature of TVM is the emphasis on nourishing the blood and vital energy, rather than concentrating on specific symptoms and its views building up the blood and energy as the key to good health (Ngueyen et al., 2016). The main treatments employed by TVM are herbal medicine, acupuncture, and moxibustion. The cornerstone of its theories is based on the observed effects of Qi (energy) in the body. Qi can be inherited from one's parents or it can be extracted from food. It is also blood and fuel gathered and stored by the body. The Vietnamese term for this practice is *cạo gió* (pronounced "cow zaw"), meaning roughly, to "scrape wind".

3.2.4. Thai traditional medicine (TTM)

The Kingdom of Thailand has its own system of traditional medicine called "Thai traditional medicine" (TTM). Historical evidence shows that Thai people began to use herbal medicine for the treatment of various symptoms and diseases and health promotion since the Sukhothai period (1238-1377). TTM knowledge was gradually developed, systematized, revised, recorded, and passed on from generation to generation throughout the country's history, from Sukothai to Ayutthaya (1350-1767), Chotchoungchatchai et al. (2012) attest that Thailand being located close to the two cradles of Asian civilization, China and India, make Thailand a melting pot where the three cultures, languages and foundation of knowledge blend and are passed on from elder to younger within families and through education.

The traditional practice of Herbal Medicine in Thailand is a mix of Ayurveda, ancient Chinese Medicine and the healing wisdom of indigenous tribes. The Thai traditional healing system, though indigenous, is drawn from Ayurveda. With the arrival of Chinese migrants to Thailand, aspects of traditional Chinese Medicine have also been integrated into traditional Thai Medicine, along with healing practices of the indigenous hill tribes of neighboring Burma, Laos and Cambodia (Poonthananiwatkul et al (2015)). This wide-ranging blend of local healing tradition has much to offer for the Western lifestyle as well.

3.3. Indigenous Health Promotion in Africa the Southern Africa

African traditional medicine is the oldest, and the most assorted, of all therapeutic systems which were briefly described above. Africa is the cradle of mankind with a rich biological and cultural diversity marked by regional differences in healing practices. In many parts of rural Africa,

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traditional healers prescribing medicinal plants are the most easily accessible and affordable health resource available to the local community and at times the only therapy that exists. Chingwaru and Vidmar (2016) argue that despite efforts by former colonized nations, traditional medicine has remained largely unrecognized and repressed. As it is in other regions of the continent, the western, eastern and southern African region has some of the richest flora and fauna which have considerable economic, medicinal and nutritional values to the health of the rural populations (Tibiri, Sawadogo, Dao, Elkington, Oudraogo & Guissou, 2015).

3.3.1. The Chavhunduka Narrative: Christianity, African Religion, and African Medicine

This study presents the account of Christianity, African religion, and African medicine in the African continent by Gordon L Chavhunduka, the account informs how the traditional health practice has evolved through and withstand the hand of colonialism and Christian missionary's era. This narrative enlightens the readers that the traditional health promotion of Africa, particularly in Zimbabwe has faced challenges from the coming in of white people who painted the African traditional red, denouncing it and calling it names such as barbaric and heathen.

This narrative further highlight how far the traditional health system has suffered western insult. The account informs that it is next to impossible to separate African medicine from Africa traditional religion. The African theology has not forgotten its approach to illness which has remain a broad one. This account by Prof Chavhunduka illustrates that although there are problems with African medicine and practice, the practice has indicated that the African people respects it and they want it that they have gone to an extend of having dual member ship to both practices of traditional health and conventional health care. Furthermore, Africans acknowledge that witchcraft exists and they shun and discourage it. The African religion in this narrative was presented to indicate that the African people acknowledge that there is a God but they pray to him through the ancestors. This narrative portrays a strong relationship of African people and their traditional beliefs; even amongst the ones who converted to Christianity, the bond remained of paramount importance to them.

Gordon L. Chavunduka (1996) the former president of the Zimbabwe National Traditional Healers, writes:

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"Early European Christian missionaries tried to destroy African religion and African medicine. Many African traditional religious rites and rituals were regarded as against the Christian faith and morals. It was also believed that African religion promoted the belief in witchcraft and encouraged people to worship their ancestors instead of worshiping God. African medicine was regarded as unscientific and some of its treatment methods were considered anti-Christian. Traditional healers were regarded as heathens because of their participation in African Traditional Religion. Thus, Africans who became Christians were discouraged by the church from taking part in African traditional religious rituals and from consulting traditional healers. This attempt to destroy African religion and medicine has not succeeded. Many African Christians have continued to participate in traditional religious rituals; they have also continued to consult traditional healers. In other words, many African Christians have dual membership in the Christian church and membership in African religion.

It is difficult to separate African medicine from African religion. There are two main reasons for this. Firstly, the African general theory of illness is very broad; it includes African theology. In other words, the theory not only attempts to explain illness and disease but also the relations between God and the universe. The second reason, related to the previous one, is that many traditional healers are also religious leaders and vice versa.

The traditional medical sector has continued to grow despite the attempts by early Christian missionaries and others to suppress it; and it has continued to grow because traditional healers are successful in curing a large number of illnesses. Traditional healers use both scientific and non-scientific or subjective knowledge. Scientific medicines are obtained mainly from plants. Many plant medicines recommended by traditional healers are correct even when judged by modern scientific methods. This empirical knowledge has been developed through trial and error, experimentation and systematic observation over a long period of time. The major sources of non-scientific or subjective knowledge are the various spirits believed to play a part in health. The social and psychological methods of treatment developed from this unscientific base often bring good results.

Participation in traditional religions is increasing. The point that was often made by early Christian leaders that many African religious rites and rituals and many of their cultural practices are against Christian faith and morals is, in fact, not correct. In recent years a number of African scholars have shown that many traditional practices that Christian churches eliminated or tried to eliminate were not, in fact, against Christian faith and morals. African religion does not encourage belief in witchcraft; it merely accepts the fact that witches exist in Africa. Witches are regarded as sinners and it is the duty of religious leaders to talk about witchcraft and to attempt to discourage its practice. African religion does not encourage people to venerate their ancestors instead of worshiping; members of African religion talk to their ancestors but worship God. African religion says, God is for everyone everywhere. God takes very little interest in the day-to-day affairs of individuals. God is not concerned with purely personal affairs but with matters of national and international importance. The ancestral spirits, on the other hand, are concerned with the day-to-day affairs of their descendants. They are the intermediaries between the living and God. People pray to God through their ancestors.

Many Africans who became Christians found it difficult to abandon their religion and medicine completely. Christian conversion was, therefore, shallow; it did not always change the African people's understanding of life and their relationship to their ancestral spirits and God.

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The way forward for the Christian church is to examine carefully African religion and medicine and other cultural aspects, with a view to identifying clearly those practices that are not against Christian faith and morals and incorporate them into modern medicine and Christian worship; if possible, they should also try to find a way out of what are considered non-Christian rites and other cultural practices. A few Christian churches are already doing this.

There is a need for dialogue between the leaders of Christian churches and the leaders of African religion and medicine. Unplanned interaction might continue to create new problems, misunderstandings and conflict. The need is for sound and genuine dialogue, involving negotiations whenever necessary".

The documentation of medicinal uses of African plants is becoming increasingly urgent because of the rapid loss of the natural habitat for some of these plants due to anthropogenic activities. The African continent is estimated to have about 216, 634,00 ha. of closed forest areas and with a calculated annual loss of about 1% due to deforestation, many of the medicinal plants and other genetic materials become extinct before they are even documented. Africa has one of the highest rates of deforestation in the world; for example, Ivory Coast and Nigeria have 6.5% and 5.0% deforestation per year, respectively, as against a global rate of 0.6% (Antwi-Baffour et al., 2014). Habitat conversion threatens not only the loss of plant resources but also traditional community life, cultural diversity, and the accompanying knowledge of the medicinal value of several endemic species.

Southern Africa has been severely affected by the HIV/AIDS, malaria and TB pandemics. Various efforts, including the use of IKS, are being promoted in various countries to mitigate the spread of these diseases. In Southern Africa, the ratio of traditional healers to the general population is approximately 1: 500 while doctors trained in Western medical sciences have a 1: 40 000 ratio (Petersen et al., 2014). These figures clearly indicate that, a great number of people in rural Southern Africa consult traditional and faith healers for their health needs.

For many people living in sub-Saharan Africa, TM is the only option available during periods of strife and economic distress. A documentation of the activities of traditional healers in various parts of Tanzania, Zimbabwe and South Africa involved in HIV/AIDS mitigation, indicates that the immune system of HIV/ AIDS patients could be boosted by indigenous medicinal plants with enzyme rich food stuffs (Kurande et al., 2013). In many Southern African countries, organizations that promote indigenous healing practices and represent indigenous healers are being recognized and promoted (for example, the Zimbabwe National Traditional Healers Association-ZINATHA and the Southern African Traditional Healers Council). In addition, African governments have

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come to realize that traditional healers are the major health manpower resource for Africa. They are largely a major source of health services for most of the people in rural areas and it is therefore recognized as the main source for PHC.

According to the World Health Organization Traditional Medicine Strategy (WHOTMS, 2000 to 2005) statistics, traditional practitioners far outnumber modern health care practitioners, and are more universally located, culturally accepted and respected. Shizha and Charema (2014) claim that in the African belief system, traditional medicine and its practitioners are a valuable resource that is markedly underutilized. Western medicine or biomedicine is often contrasted with the approach taken by traditional medicine practitioners. For the millions of indigenous people in Southern Africa, the right messengers remain the traditional health care practitioners which include the popular known sangomas, inyanga or n'anga.

In Malawi, Lesotho, South Africa, Swaziland, Zimbabwe and Zambia, most people associate traditional medicine with herbs, remedies (mishonga) and advice imparted by sangomas or inyangas, and with strong spiritual components (Kazembe, Charumbira & Munyarari, 2012). Notably, these indigenous medicinal practices and healing strategies are slowly gaining momentum challenging the monolithic view that accord Western medical practices a high status. However, despite the TM popularity, it is to some extent being abused by the practitioners. This abuses to traditional medicine is the widespread reported cases of quackery and fake healers and healing, amid the concomitant unemployment in Zimbabwe, there is a marked increase in the ranks of self-proclaimed fortune tellers who masquerade as traditional healers, among whom there are, unfortunately, quite a few charlatans. Therefore, to curb issues around it, a mechanism for integration with the conventional health practice is needed for a sustainable health system in the third world.

3.4. Health promotion in Zimbabwe

In this section the recent and current health promotion trends in Zimbabwe are outlined and then its link and reliant on indigenous health practices for primary health care is discussed thereof.

In the period between 1980 and the mid-1990s, Zimbabwe developed one of the strongest economies and health systems in the Southern Africa region. Economic challenges associated with macroeconomic policy changes, economic structural adjustment programs (ESAP) and the

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Zimbabwe Democracy and Economic Recovery Act, 2001 (ZIDERA) and effects of natural disasters, recurrent droughts, have led to rapid decline in economic indicators. This situation has led to the resurgence of indigenous medicine and it became the central health care system for the majority (African Health Observatory, 2015).

Diseases affecting the Zimbabwean population include malaria, tuberculosis, HIV and AIDS, typhoid, cancer, and pregnancy related diseases and pre-natal complications. Significantly, most of them are preventable. The observed high disease burden of preventable diseases is characteristic of many low to middle income countries but specifically for Zimbabwe. This is due to inadequate health financing over the past 17 years (Deaton & Tortora, 2015). The health indicators deteriorated after the major economic activities for Zimbabwe, that is, tourism, mining and agriculture, were severely affected by the economic collapse. In the past 17 years, Zimbabwe has been characterized by an economic meltdown which was characterized by hyperinflation, hunger, starvation as well as poverty which then put a halt on the conventional health financing system (Zimbabwe Health Assessment, 2015).

The first quarter of the year 2018 saw a massive tooling down of Zimbabwe's junior doctors against poor payment and unsatisfactory working conditions. Consequently, it led to the closure of all central hospitals, children's units, provincial hospitals and the cessation of emergency lifesaving procedures throughout the country. According to the representative body of junior doctors, the Zimbabwe Hospital Doctors Association reported that in March 2018 there were 300 junior doctors working in Zimbabwe's health government institutions (Green, 2018). This therefore puts Zimbabwe a long way from the World Health Organization's recommendation of the minimum threshold of 23 doctors, nurses and midwives per 10 000 population. According to the Zimbabwe National Health Strategy (2016-2020), currently every district has at least 2 doctors, every primary health care centre has at least 2 qualified nurses, 59% of administrative wards are serviced by an Environmental Health Technician and 60% of villages have access to a village health worker (WHO, 2018). These ratios are below standard and inadequate given that a district might be having two government hospitals and several clinics.

The Zimbabwe Service Availability and Readiness Assessment Report of 2015 says that health studies and surveys that have been carried out in the country all point towards inadequacies in the six World Health Organization (WHO) Health System Building Blocks. These building blocks include human resources, medical products, vaccines, and technology including infrastructure,

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health financing, health information, service delivery, leadership and governance that are prerequisites for a functional health delivery system (Sarkodie & Strezov, 2019). Given the inadequacy, in Zimbabwe, village health workers play an essential role in the primary healthcare system and the fight against HIV/AIDS. The village health workers work as volunteers with great love of the community and they receive ongoing training, as well as uniforms and health kits. They are given a bicycle, which gives a low-cost and sustainable mode of transport that allows them to travel up to 20 km a day to reach remote rural families. According to Green (2018), much of the training and assistance given to these health workers is being rendered by NGOs like Red Cross. The too much dependent on the donor funding which could not meet the health needs of the majority has made many Zimbabwean people to choose traditional medicine which is easily accessible and culturally appealing.

2.4.1. Indigenous Health Promotion in Zimbabwe

The health system collapsed and for many poor Zimbabweans there was nowhere else to go. Traditional healers were and are still often the first and last line of defense against the most contagious and debilitating diseases that plague their lives. In the Zimbabwean situation, not only did people resort to traditional medicine, there was a massive rise in the works and genesis of witch-hunters (*Tsikamutanda*) and faith believers (prophets). Bhebhe (2016) claims that there was an increase in the number of witch-hunters known as the *Tsikamutanda* (step on a magical stick and we will tell whether you are a witch or not) who go around the country cleansing homes and villages of witches to avoid sickness and misfortunes. All ethnic groups in Zimbabwe are known to use one form of TM or another, including spiritual healing and indigenous health promotion.

Traditional medicine (TM) is either the mainstay of health care delivery or serves as a complement to conventional medicine (Shalukoma et al., 2016). Among all Zimbabwean tribes (Shona, Zezuru, Kalanga, Venda, Tsonga, Ndebele, ndau etc), traditional practices and herbal medicines have historically been used as primary treatment for many diseases and ailments such as cancer, malaria, mental illness and HIV-related problems like nausea, depression, and insomnia (Mapara, 2009). In Zimbabwe, for both rural and urban poor people, traditional medicine is often the first and last line of defense against the most contagious and debilitating diseases that plague their lives (Maponga et al., 2016). In Zimbabwe, the role of IKS in health promotion has not only been for a long time helped in sustaining the African health only but it preserved the culture and heritage. Maunganidze (2016) argues that with TM, culture becomes prominent and influences

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people's perspective on what belongs to their culture and the other's culture and where they seek healthcare.

Maunganidze (2016) further states that traditional medicine identifies one's culture. When it comes to choosing TM prior to Western medicine, it is not only lack of or poor healthcare and people's financial resources, but also culture influences the choice. Apart from preserving one's culture, studies have showed that in contemporary societies, TM is called complementary medicine as it is there to assist the conventional medicine. In Zimbabwe, it was pointed out that it was important for them to consult both a traditional healer and the local clinic when they fell ill, even if they believed that only the professional nurse or doctor could treat them. For a broken leg, for instance, the patients still went to a traditional healer for good luck and reassurance. This used to be the case but now the reverse is true.

3.5. Nature of traditional health practices and duties of indigenous health practitioners

Normally, the vocation of traditional healer runs within tribal families and is practised for the benefit of the community and traditional healers inherit their spiritual gifts and skills from either or both sides of their paternal or maternal ancestral lineages (Chitando, 2016). To maintain good relationships with these ancestral spirits, the traditional healers periodically make sacrifices and offerings to those spirits. According to Hewson (2015), traditional health practitioners come in four different types: the diviner, whose duty it is to make a diagnosis, the herbalist, who prescribes and treats ailments, the traditional midwife, and the exorcist, who plays a large part in freeing people from troublesome and evil spirits including unseen mysterious forces, and the healer's ability to convey messages from the spiritual world.

These traditional healers use various methods and techniques such as divination, cleansing rituals, protective amulets, and herbs to cure and heal. Despite all these divisions, Jones (2018) attests that one practitioner can perform more than three aspects of the traditional healer, depending on the calling, skills and knowledge. The traditional health practitioner is an individual with knowledge of herbs, roots, and even fruits that can prevent, protect, or cure diseases and pain. Cooke (2017) propounds that when people visit the traditional healers, the first need for healing is to have confidence in the healer and his/her supernatural powers and the healer's ability to deal with the health condition. For instance, if the sickness is supernaturally caused, then the healer uses rituals apart from herbal medicines.

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Anderson (2018) argues that dreams also carry a whole range of significance in the traditional Shona healing practices since people may draw insight and new meanings through the dreams, and some traditional healers are gifted in helping people interpret dreams and use the gathered knowledge towards healing. In this case, diviners in particular, interpret dreams and focus on the cultivation of higher emotional states and an awareness of the spiritual realities. Unfortunately, like any other health delivery system, the traditional Shona system is susceptible to abuse and to unscrupulous practitioners. The Zimbabwean National Association of Traditional Healers (ZINATHA) has therefore been established as a monitoring organization, and every traditional healer is obliged to register with the association.

Traditional healing in Africa shows a collectivists idea when dealing with health problems through seeing both personal and communal responsibility as vital in matters of life, illness and suffering. Shoko (2016) testified that ethnomedical approach in traditional healing is that a healer had to deal with the patients and, at the same time, work with the families. In this regard, illnesses and suffering are seen not only as caused by outside agents such as microorganisms, accidents, or unhygienic practices but also as involving spiritual factors. During diagnosis, the traditional healer can interview a family man to set up the facts leading to his illness. He explores what the man had been doing with respect to his unseen but present ancestral spirits and whether he had been carrying out his duties towards his family; both nuclear and extended. Through the diagnosis process, the traditional healer uses various approaches including rituals, dream work, symbolic representations, and herbal treatment (Kajawu et al., 2016).

Shalukoma, Duez, Bigirimana, Bogaert, Stévigny, Pongombo, and Visser (2016) define a traditional healer as a respected member of the community who plays a vital role in the lives of many. Traditional healers include the herbalist, spirit mediums and the diviners. Diviners are believed to be specialists in divination within the supernatural context, which gives them the ability to divine the cause of illness and misfortune. The herbalist specializes in the production and identification of herbal medicines. Singh (2014) claims that one major difference between conventional medicine and traditional African medicine, is the way of viewing illnesses and their treatments.

The traditional medicine, unlike its Western counterpart, takes an integrated approach, which is based on the premise of interconnectedness, and often includes indigenous herbalism in its treatment. African traditional belief defines health as a concept which is made up of various

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aspects which include physical, spiritual, moral, and social (Mposhi et al., 2013). Therefore, if these parts function together harmoniously, a person will be in good health. Similarly, the treatment of an ill person involves not only aiding his/her physical being, but may also involve the relevant spiritual, moral, and social components of well-being as well.

The use of indigenous or local knowledge for the treatment and prevention of diseases is not new in African cosmology. Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being (Tibiri et al., 2015). TM has kept its popularity in all regions of the developing world and its use is rapidly spreading to industrialized countries. Health promoters using IK are mostly herbalists, diviners, traditional birth attendants (TBAs), traditional healers, witch-hunters, spirit mediums mid-wives, and traditional psychiatrists (Shizha and Charema, 2014). In most African countries, particularly in rural areas, traditional healers are widely consulted in the search for causes of distress, illness and misfortunes. Ritual cures are constantly performed to help the sick.

Mafuva and Matarira (2014) established that the causes of illness and death that are rooted in the African belief are sorcery, witchcraft and superhuman forces that have continued to thrive in Africa. Diviners in Zimbabwe are perceived as a skillful clairvoyant who are viewed as holding a key to the secrets of lifelines, having knowledge of the underworld, and having an ability to see things and send that knowledge to others in need (Shizha & Charema, 2014). Chavunduka (1978) claims that for one to become a clairvoyant, a candidate is usually called upon by the ancestral line's deity to the art of studying and practicing clairvoyance. Diviners are responsible for determining the cause of illness, which in some cases is believed to stem from spirits and other evil influences. All the practitioners of indigenous health practices, diviners and traditional herbalists, traditional birth attendants (TBAs), make extensive use of indigenous plants to aid childbirth.

The indigenous health promotion practice has proved against all odds that they can cure even the more acute diseases conditions that conventional medicine strives to cure or sometimes fails to do so. The work by Kajawu et al. (2016) attests that given that in Zimbabwe there are few biomedical practitioners and particularly few who have specialized in mental health care, such as psychiatrists, psychologists and psychiatric nurses, the TM have managed to cure mental illness.

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The well-known acute mental illness in Zimbabwe which is said to be rooted in the avenging spirit (*ngozi*), has been cured since time immemorial wherein the traditional practitioners believe that *ngozi* can cause mental illness. Therefore, if the spirits are appeased then the mental illness is cured. Mutambara (2014) reports that most patients with mental disorders are presented as either bewitched, tormented by an aggrieved spirit or suffering from social or economic hardships. However, in Zimbabwe, the most common cause for these mental disorders is believed to be witchcraft which emerges from evil minded people who are jealous and harm others with magic. It is believed that when they are bewitched, some patients may develop confusion after being attacked by evil birds or goblins sent by witches (Bhebhe, 2016).

3.6. Classification of indigenous health promotion practices

Given the lengthy existence of traditional health promotion which is based on indigenous knowledge even before the advent of modern medicinal practices, it is therefore plausible to assume that the primary health care strategies (promotive, preventative, curative, rehabilitative, and surgical) principles have been fulfilled since time immemorial. The modern development of health promotion also recommends that there is a need to include local people, their traditions, and practices in Primary Health Care (Miller, 2015)

Preventative practices of traditional medicine include several elements or disease prevention. In the past, the spread of highly infectious diseases such as smallpox was prevented by deserting places where the epidemics occurred. Moreover, people were inoculated by taking pus from a sick person during special rituals. Sweeping or covering floors with plants is another traditionally practiced disease preventive measure. Other methods of disease prevention include isolating people with contagious diseases, prohibition or controlling movement and taking children away from the affected areas (Mafuva & Matarira, 2014).

As noted above, *kitabs* in the Ethiopian traditional medical system are also used for protecting an individual against evil eye, as well as snake and scorpion bites (Birhanu, Endale & Shewamene, 2015). Amulets, arm rings, hair style and eye make-up (antimony or *kool*) are also supposed to protect from the evil eye. Still other medicines are available for use as charms against an enemy. In addition, cultural rituals and scarification are employed in disease prevention. Ebijuwa and Mabawonku (2015), posits that in Igbo culture in Nigeria, during the first four weeks after birth, the mother and the child are secluded and the mother is relieved of duties, and they are cared for

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by the grandmother of the newborn. The new mother is fed a stimulating hot soup made of dried fish, meat, yams, a lot of pepper and a special herbal seasoning called udah, which helps the uterus to contract and helps in expelling blood clots (Stanfield & Browne, 2013).

In Zimbabwe, traditional healers want to promote the use of a traditional spell that ensures fidelity, alongside the more conventional methods of condoms and abstinence to curb the spread of Aids in the country. The traditional healers in Zimbabwe especially those of foreign origin came up with the idea of using a technique that involves magically locking women and immobilizing men, to bar them from having extra-marital sex (Mbereko & Mahlatini, 2014). The proposed technique uses traditional herbs to cast a spell that can be administered by a healer even in the absence of the subject. It has become popularly known in Zimbabwe as the central locking system or immobilizer because when applied, the spell is supposed to ensure that one cannot have sex outside marriage. In a bid to minimize pre-marital sex, the Zimbabwean Kore-kore communities are still conducting the traditional virginity test among teenagers and single girls to ensure that they have abstained from sexual activities and its adverse health effects before marriage.

3.6.1. Taboos in preventative and promotive indigenous health

Taboos can be described as prohibitions of a society, which entails what must not be done because the society frowns upon it. Taboos touch every aspect of the individual's life in African society, there are professional taboos, health taboos, religious taboos, moral taboos and sexual taboos (Mhaka, 2014). The tradition of taboos among Africans is as old as the existence of the people. The Shona, the largest ethnic group in Zimbabwe, often use taboos (*zvieraera*) as one of the ways of teaching young members of their society and among other practices, encourage conformity to healthy living.

One of Zimbabwean taboos is incest. Incest is a serious taboo among the Kore-kore people that a sexual act within the family is an abomination because blood mixing offends the ancestors and the gods (Odoi & Agbozo, 2014). Scientifically, however, intra-family sexual intercourses breed abnormal births, birth defects and diseases as modern science establishes that incest causes haemophilia and other dangerous birth defects as the gene pool within the family is corrupted. Another taboo is that one must not leave soup overnight without putting charcoal into it. It is said that should such a thing happen, a ghost will visit the house at night dip a finger into the soup and should someone eat the soup, the person will get sick and die (Mhaka, 2014). Scientifically,

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charcoal is known to have the property for absorbing the carbon content of liquids and thus prevents the action of micro-organisms on the soup. The soup with charcoal can therefore stay overnight without going bad. The other taboo is that one must not sing while bathing. The folk explanation is that the mother of a person who does this will mysteriously die. There is a scientific explanation to this taboo that suggests that the soaps used in the olden days contain very acidic substances and made the soups poisonous when they swallowed in large quantities.

The taboo is aimed at protecting people from the harmful effects of traditional soap. Historically, potassium hydroxide, extracted from the ashes of bracken or other plants, is the main ingredient in soaps. According to conventional medical scientists in West Africa, some ingredients for traditional soap making are white wood ashes from a hardwood tree, a fat or some oil, an amount of salt and a few small pieces of charcoal (Ekwochi et al., 2016). Historically, the Shona people believed that a widow or widower must not be present at the cemetery for the burial of their spouses. This, according to the study by Odoi and Agbozo (2014), disrupts the smooth separation of the dead spouse from the living spouse and the departure of the dead to the world of spirits. The ghost of the dead person, as believed, will visit, and take the soul of the living spouse away at night. This taboo has a psychological cum scientific explanation. The taboo is aimed at protecting the mental health or emotional well-being of the living spouse as the emotional effects of the separation of spouse could result in mental trauma or death of the living spouse.

3.6.2. Curative indigenous health promotion practices

Traditional medicine is commonly used to treat a variety of diseases employing substances and herbs as recommended by professional traditional medical practitioners. Traditional medicine is used to treat conditions which include gastrointestinal disturbances, respiratory disorders, sexually transmitted infections, tuberculosis, impotency, hemorrhoids, rabies, intestinal parasites, skin problems, liver diseases, mental disorders, hypertension, diabetes, gynecological conditions rheumatism, malaria and others (Fenetahun, Eshetu, Worku & Abdella, 2017). Large scale community interventions like home herbal gardens in India have demonstrated that many simple primary health care problems like fever, upper respiratory tract infections, gastro-intestinal problems such diarrhea, dysentery, worm infestations, hepatitis, anaemia, arthritic conditions, and certain gynecological conditions can be managed at household level through simple herbal home remedies and early identification and interventions.

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Most of the plants found in Africa are endemic to that continent, the Republic of Malagasy having the highest rate of endemism and undoubtedly, medicinal plants and the drugs derived from them constitute great economic and strategic value for the African continent (Dodo, 2015). The plant species has become central in traditional health, Africa has a long and impressive list of medicinal plants based on local knowledge, for instance *Securidaca Longepedunculata* is a tropical plant found everywhere in Africa (Fabelau & Baffour et al., 2008). The local/indigenous knowledge decides the different use of a certain herb or animal product. The dried bark and root are used in Tanzania as a purgative for nervous system disorders. Throughout East Africa, the plant's dried leaves are used for wounds and sores, coughs, venereal disease, and snakebite.

According to Nyirenda and Maliwichi (2017), in Malawi, the leaves are used for wounds, coughs, bilharzia, venereal disease, and snakebite. The dried leaves in Malawi cure headaches and the dried leaves act on skin diseases in Nigeria. According to one pharmaceutical researcher, the root is used in Bechuanaland and Rhodesia for malaria while the same part of the plant is used for impotence in Tanganyika (Albertyn et al., 2014). Meanwhile, in Angola, the dried root is used as both a fish poison and (in botanical testimony to the power of love) as an aphrodisiac. The same dried roots have religious significance in Guinea-Bissau and are understood to have a psychotropic effect. The root bark is used for epilepsy in Ghana. The above sentiment suggests that the Africa traditional; medicinal practices vary from place to place and culture to culture as dictated by the beliefs of the region.

The traditional herbal medicines like the African potato (Hypoxis hemerocallidea), Sutherlandia, known as cancer bush (Bepe et al., 2011), and others, such as Acacia karroo (Hayne Tree), in Zimbabwe known as *muvunga*, whose roots extract is drunk as a remedy for convulsions and treatment of STD infections, gonorrhoea and syphilis (Maroyi, 2013), have all been demonstrated to be effective. Fenetahun et al. (2017), found out that consumption of Chinese green-tea was associated with lower risk of stomach cancer, including oils from plants, such as soya, cashew and shea butter saturated fats and wild fruits. Vegetables with high fiber content which patients were encouraged to consume were helpful in cleansing the body system. Though these diet and nutritional therapies did not cure the disease, they, however, improved the immune system of the patients.

The therapy also involves the elimination of stress bound foods and liquids from patients' diet, such as coffee, black tea, sugar, salt, white flour, as well as concentrated carbohydrates, such as

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white rice. The documentation also shows that natural juices, and traditional foodstuffs and medicinal preparations can improve the immune system of AIDS patients and may be far less tedious in relation to their effects and cheaper than a treatment based purely on Western-oriented medication (Maroyi, 2013). In a study conducted in Amhara, Ethiopia, it was confirmed that a large number of plant medicines are used, and for the purpose of references, most *medhanit awakis* possess pharmacopoeias of minerals and animal-derived substances that are used in indigenous health promotion (curative) (Ashenafi, 2016).

3.6.3. Indigenous surgical health practices

Traditional practices considered to be related to surgery include bone-setting, uvulectomy, circumcisions, bleeding and cupping, cautery, scarification, and tooth extraction. The setting of bones is regarded as an important surgical procedure which requires a certain degree of skill and experience on the part of the healer. Other procedures are indicated for more specific conditions such as rheumatism, bleedings, swelling, wounds, headache, localized infections, and snake and scorpion bites. Midwifery is one of the most common practices of traditional Zimbabwean medicine. It is performed by traditional midwives known in Shona as *Nyamukuta* (traditional birth attendants) and most TBAs are women. Estimations suggest that around 60% of child deliveries in the world are managed by traditional birth attendants, though many official policies do not recognise them, more countries are realizing the community health education role that healers can perform (Chamberlain, Fergie, Sinclair & Asmar, 2016). Depending on the need, they carry out their practice with or without the administration of medicines.

Schierenbeck, Johansson, Andersson, Krantz and Ntaganira (2018), studied indigenous healing practices and self-medication among pregnant women in Cape Town, and found that most Xhosa speaking women follow indigenous health practices for both themselves and their babies because of the need to strengthen the womb against witchcraft or sorcery, to prevent childhood illnesses, and to treat symptoms they perceive that biomedical services would not be able to treat. In pregnancy, herbs or minerals are often used as a tonic to clean the womb, to ease delivery, to induce labour, and to protect the child from evil and have a healthy child, the giving of herbal remedies for pain, sickness, or discomfort; abdominal massages, offering comfort to mothers and giving them a sense of security (Schierenbeck et al., 2018). They also assist with the delivery of the baby and advise and assist the new mother on how to care for the baby after it is born.

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3.7. Challenges facing the indigenous health promotion practices

This section will discuss the challenges faced by the traditional health practitioners.

3.7.1. Influence of Christianity, civilization, urbanization globalization and colonialism

Over the years, urbanization, globalization, forced migration and emergence of new religious values have profoundly affected the indigenous health promotion practices. The globalised panic going with the emergence of charismatic faith-based or prophetic denominations has not spared the rural communities. Since TM was considered superstitious and unchristian, faith healers are becoming more popular and traditional health practices have lost popularity to some extent. In Zimbabwe, the majority of people who use TM are particularly the rural dwellers and the older generation because they are more familiar with the practice (Mhaka, 2014). However, the absence of active involvement of traditional herbalists and healers in the design and administration of public health programs has contributed to the erosion of IK.

Some schools of thought argue that the emergence of Western medicine at the dawn of industrialization has brought about scrutiny to the practice of traditional health promotion. After the settlement of Europeans in Africa, the missionary influence, as well as repressive political ideologies of colonial administrators outlawed African medical practices by castigating them as heathen, primitive, barbaric, and uncivilized (Shizha, 2008). This colonial view of traditional healing as being part of a barbaric civilization was widely held. It was perceived as being out of tune with the enlightenment philosophy and the ideas on modernity and enlightened civilization (Shizha, 2005). Traditional healing was believed to be associated with illiteracy, irrationality and chaos. Consistent with reflexive sociology, the blame for the loss of IK, particularly in the health sector, cannot be placed on groups. Reflecting on villagers lived experiences, IK has lost importance in the public space, although at an individual level, villagers still trust it.

The pattern of seeking TM has changed and varied over the years, partly due to the establishment of rural clinics and village care systems in post-colonial Zimbabwe. Although some patients and their families often consulted traditional healers, even after hospitalization, the trend has changed over the years. However, the introduction of free health care in public hospitals and clinics in the post-colonial period was not the only contributing factor to the reduced number of locals seeking assistance from traditional healers. The sudden disappearance of traditional ceremonies such as

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appeasing the spirits of the dead (*kupira vadzimu*), reduced the symbiotic connection between the dead and the living (Bhebhe, 2016). The practice of appeasing the spirits of the dead also acted as a moral cord that bound the family members and communities together. It was also believed to protect family members from unnatural death, wherein a spiritually possessed medium would diagnose the cause of disease and prescribe medication.

3.7.2. Disease burden

In Africa, more than eighty percent (80%) of the continent's population rely on plant and animal-based medicine for health care requirements (Hammersmith, 2007). For the most part, the plants and animals used in traditional medicine are collected from the wild, and in many cases, demand exceeds supply. As Africa's population grows, demand for traditional medicines is increasing and pressure on natural resources is becoming greater than ever. Throughout Africa, many health-oriented ministries are now encouraging the use of local medicinal plants, and have established departments of traditional pharmacopoeia within the ministries to implement this policy (Wardle & Seely, 2012).

A heavy burden of communicable diseases such as HIV, malaria and other parasitic diseases, pneumonia, diarrhea, tuberculosis, coupled with chronic diseases, such as diabetes, ischemic heart diseases (a situation often referred as a double burden), persistently torment lives in low income countries such as Zimbabwe. Foto, Chapman and Lashari (2016) posit that high maternal and child mortality, rapid demographic changes and urbanization, underutilization of public healthcare, ineffective health support systems for the poor population, increasing privatization of health facilities, migration of medical professionals, environmental changes and related epidemics are some other major public health concerns in such economies. High out of pocket spending on health in countries like Zimbabwe, which is around 78%, and lack of appropriate health insurance or social security are other concerns that have put much pressure on indigenous health promotion practices.

Shamu et al. (2016) state that, in the wake of globalization, there is a perceived challenge of increased inaccessibility and unavailability of healthcare to the economically disadvantaged people of such societies, hence indigenous health practices become central. All these noted pressures have resulted in the extinction of some herbs, as well as well as paralyzing some of indigenous health practices. Concern has been expressed that increased demand for wild plants

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used in traditional African medicine is endangering local plant populations. For example, the Washington-based group, Future Harvest, says that a $220 million annual market for Prunus Africana as a prostrate remedy could lead to extinction of the slow-maturing evergreen tree in the African wilds (Kazembe et al., 2012). The disease burden has also created a space for fake traditional healers who then ruin the standards and essence of indigenous health practices.

3.7.3. Lack of clinical tests and research

Both traditional and Western medicines can have negative or dangerous effects. However, calls have been made that further research be undertaken to ascertain the efficacy and safety of several of the practices and medicinal plants used by traditional medicine systems (WHO, 2013). Ekor (2014) confirmed that the global use of herbal medicinal products continues to grow and many new products are introduced into the market, public health issues and concerns surrounding their safety are also increasingly recognized, with many of the herbal medicines and practices believed to be untested and their use not checked. It is also common knowledge that the safety of most herbal products is further compromised by a lack of suitable quality controls, inadequate labeling, and the absence of proper patient information (Raynor et al., 2011). According to Mapara (2009), species of the aloe plant are extensively used in traditional African medicine, but some forms, such as Aloe globuligemma, have been reported to be toxic, and can result in death if misidentified.

Serious side effects, even death, can result from incorrect identification and consumption of healing plants. The externalization and appropriation of Hoodia gordinii and its international marketing as an appetite-suppressant is a disservice to the san people of Botswana, South Africa and Namibia who have been denied their right to their material knowledge through patents and intellectual property rights that have excluded the San. Lawal et al. (2015) add that, indigenous dental health practices of using the Arbian Pennisula leafy substance (Qat) has complications which may lead to worsened dental appearance. In addition to causing severe greenish discolouration of teeth, Qat consumption can cause adverse effects such as oral mucosal lesions, dryness of the mouth, formation of cavities and development of periodontal disease.

Ekor (2014) observes that in most countries, herbal medicines and related products are introduced into the market without any mandatory safety or toxicological evaluation, and many of these countries also lack effective machinery to regulate manufacturing practices and quality

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standards. These herbal products are continuously made available to consumers without prescription in most cases, and the potential hazards in an inferior product are hardly recognized. In spite of the positive perception of patients on the use of herbal medicines and alleged satisfaction with therapeutic outcomes coupled with their disappointment with conventional allopathic or orthodox medicines in terms of effectiveness and/or safety, the problem of safety of herbal remedies continues to remain a major issue of concern. Rasool (2012) attests that the general perception that herbal remedies or drugs are very safe and devoid of adverse effects, is not only untrue, but also misleading. Posadzki, Watson & Enst (2013) attest that herbs have been shown to produce a wide range of undesirable or adverse reactions, some of which can cause serious injuries, life-threatening conditions, and even death, with numerous and irrefutable cases of poisoning having been reported in several studies.

3.7.4. Malpractice embedded in Indigenous health promotion

Mills, Singh, Wilson, Peters, Onia, and Kanfer (2006) point out that studies conducted identified important risk factors for the spread of HIV among this popular indigenous health promotion practice wherein it was found that the use of unsterilized instruments was an area of considerable concern in the spread of disease. The reuse of contaminated blades after scarification and circumcision can contribute to medical exposure to diseases. Cutting instruments were being used on a series of patients in clinic sessions and postoperative hypodermic needles used for herbal injections are routinely reused (Donnelly et al., 2018). Additionally, healers' get into contact with patients' blood and other body fluids through siphoning procedures. A lack of hygiene was identified as an all-important risk factor of contracting HIV (Mills et al., 2006).

Although not common, there are also concerns about exploitation by the healers, in their methods of treatment. A study in the Mopani district of South Africa revealed that there have been HIV infections related to sexual contact with the healers as some spiritual healers engage in sexual relations with patients as a form of treatment (Mudau et al., 2016). This issue is of most concern with the held view that sex with a virgin can cure sexually transmitted diseases. This notion has resulted in child rapes, and has contributed to the burden of illness. A further concern relates to the herbal medicines used by traditional healers and the prescription of toxic plants for HIV treatment has resulted in severe adverse events, including death. Another fundamental challenge to TM is the widespread reported cases of quackery and fake healers and healing, amid the concomitant unemployment in Zimbabwe (Duri, 2017).

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3.7.5. Poor documentation of traditional health practices

Indigenous knowledge is the main source for indigenous health promotion practice and there is therefore a need for proper documentation and protection of the knowledge itself. According to Sithole (cited in Mapara, 2009), indigenous knowledge is threatened by the fact that it is mostly preserved through human memory and passed on through generations by word of mouth, rather than in written form. This makes it vulnerable to manipulation. There are several factors that contribute to the loss of indigenous knowledge. For example, development processes, like rural/urban migration and changes to population structure because of famine, epidemics, displacement or war may all contribute to the loss of indigenous knowledge. Nyumba (cited in Mapara, 2009), notes that indigenous knowledge is under threat from modern technology because even in remote areas, the powers that push global or just non-local content, such as radio and television broadcasting and advertising, are much stronger than those pulling local content.

3.7.6. Intellectual property rights

The World Intellectual Property Organization argues that there is a need to protect indigenous or traditional knowledge from exploitation for financial gain by third parties. Mapara (2009) argues that the Western society accumulates data relating to non-Western societies and appropriates their knowledge systems. Hammersmith (2007) voices his concern on the vulnerability of indigenous knowledge because, by nature it is exploitable and continues to be exploited for financial gain by multinational and international drug companies. Mugabe (1998) concurs, arguing that plant derived prescription drugs in the United States of America are derived from forty (40) species, of which fifty percent are from the African sanctuaries.

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CHAPTER FOUR

RESEARCH METHODOLOGY

4.1. Introduction

Yin (2013) contends that methodology is a coherent group of methods that complement one another and that can deliver data and findings that will reflect the research question and suit the researcher's purpose. This section of the study illustrates and explains how the data collection was planned and executed. This chapter also provides an overview of methodology that was used in the study and discusses the research paradigm, research design, study area, population sampling, data collection, data analysis and ethical considerations.

4.2. Research Paradigm

In social science research, the term 'paradigm' is used to describe a researcher's worldview and this worldview is the perspective, or thinking, or school of thought, or set of shared beliefs, that informs the meaning or interpretation of research data (Avramidis & Norwich, 2018). This philosophical assumption or research paradigm inherently reflects the researcher's beliefs about the world that s/he lives in and wants to live in. It constitutes the abstract beliefs and principles that shape how a researcher sees the world, and how s/he interprets and acts within that world. Similarly, the pundits of qualitative research, Mckenney and Reeves (2018), explain research paradigms as human constructions, which deal with first principles or ultimate indications of where the researcher is coming from to construct meaning embedded in data.

Many paradigms have been proposed by researchers, but Candy (1989), one of the leaders in the field, suggests that they all can be grouped into three main taxonomies, namely Positivist, Interpretivist, or Critical paradigms. The present study was based on an interpretive paradigm. The adoption of the interpretive approach is informed by the work of Thanh and Thanh (2015) who indicate that, interpretivism is a trend of research approach, and it prefers using qualitative methods in data collection. This tight connection between an interpretivist paradigm and qualitative methodology, as one is a methodological approach and one is a means in collecting data. In this study the investigator adopted and interpretivism paradigm in a qualitative approach to seek experiences, understandings, and perceptions of traditional health practitioner in

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promoting health. The researcher in this study believes that it is possible to understand others' experiences by interacting with them and listening to what they report through in-depth interviews.

4.2.1. The Interpretivist Paradigm

The central endeavour of the interpretivist paradigm in this discourse is to understand the subjective world of human experience (Guba & Lincoln, 1989). This approach tries to get into the head of the subjects being studied, so to speak, and to understand and interpret what the subject is thinking or the meaning s/he is making of the context. In this study the subjects were the registered traditional health practitioners of the Pfura rural district council. Every effort was made to try to understand the viewpoint of the subject on the promotion of indigenous health practices, rather than the viewpoint of the investigator. The interpretivist approach allowed the researcher to explore the role of traditional health practitioners in promoting health in a rural setting. The interpretivist approach of the case study of the Pfura rural district has drawn a conclusion of individuals, units, or cases within specific contexts, and involved description and exploration.

Interpretivism as the philosophical assumption in this discourse, rendered emphasis which was placed on understanding the individual/subject and their interpretation of the world around them. Hence, the key tenet of the Interpretivist paradigm is that reality is socially constructed (Paul et al.,2016). With interpretivism, it is assumed that the researcher and their subjects are engaged in interactive processes in which they intermingle, dialogue, question, listen, read, write and record research data (Yin, 2013). The assumption of the interpretivist ontology means that a researcher believes that the situation studied has multiple realities, and that those realities can be explored and meaning made of them or reconstructed through human interactions between the researcher and the subjects of the research, and among the research participants.

Antwi and Hamza (2015) argue that an interpretive paradigm is underpinned by observation and interpretation, thus to observe is to collect information about events, while to interpret is to make meaning of that information by drawing inferences or by judging the match between the information and some abstract pattern. In adopting this paradigm, the researcher utilized data gathered through in-depth interviews, wherein the researcher was an observer and interviewer. The interpretivist paradigm also offered the basis of validating the research findings. Qualitative research gurus like Guba (1981), suggest that in research conducted within the interpretivist paradigm, criteria of internal and external validity, and reliability, should be replaced with four

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criteria of trustworthiness and authenticity. These include credibility, dependability, confirmability and transferability and they have been elaborated in the later sectionss under this chapter.

4.3. Study design and approach

4.3.1. Qualitative research approach

The study utilized the qualitative research approach which is derived from the interpretivist tradition in which truth is considered complex and dynamic and can be discovered only by studying people as they interact in their natural setting (Creswell, 2014). Consistent with this tradition, a qualitative approach was chosen in this discourse because it provides valuable insights into the local perspectives of study populations on the aspect of the role of traditional healers in promoting health. The great contribution of qualitative research is the culturally specific and contextually rich data it produces, and it is proving to be a critical design of comprehensive solutions to public health problems in developing countries. Creswell (2013) states that the qualitative approach is a situated activity which positions the researcher in the world and consists of interpretive and material practices that make the world visible and transform it. The merits of qualitative research are that it aims to explore and to discover issues about the problem on hand, because very little is known about the problem.

In exploring the role of traditional health practitioners in promoting health in a rural setting, the qualitative approach utilized in-depth interviews. The study approach qualitatively described the roles which included the nature and range of practices of traditional health practitioners in the Pfura rural district community, as well as challenges that were faced. Furthermore, a qualitative approach allowed the researcher to acknowledge the importance of multiple sources of evidence, rather than just relying on one source of evidence. With the qualitative approach the study used in-depth interviews which were audio recorded, field notes and observation was utilised too. Yin (2014) postulated that this triangulation leads to creating converging lines of enquiry.

4.3.2. Study design

Lambert and Lambert (2012), postulate that a research design is the plan or structure of the research project which indicates what type of study is planned and what kind of results are expected from this project. It specifically focuses on the results of the research. The main function of a research design is to make sure that the information gathered throughout the research

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answers the initial question unambiguously. The present study adopted an explorative and descriptive research design which utilized a qualitative approach in gathering of data.

According to Yin (2017), an exploratory research design is referred as gathering information in an attempt to shade light particularly on research areas that has not been studied more clearly. The exploratory research design was adopted as a proper design since the researcher was not well versed with the traditional health practices in given rural settings. Given the chosen interpretivist paradigm and its connection to a qualitative nature, the exploratory research design became a fusing factor in this study.

Descriptive research is the “exploration” of the existing certain phenomena wherein the existing phenomena are not known to the researcher (Vaisamoradi, Turunen & Hondas, 2013). A descriptive study design involves a straight forward descriptive summary of the informational contents of the data that is organized in a logical manner. Descriptive research gives a detailed account of a social setting, a group of people, a community, a situation, or some other phenomenon. Researchers engage in descriptive studies set out to find who takes part in an event, where and when it occurs, and what happens, without exploring the causal relationships involved in that event. The present descriptive study aimed at examining the role of traditional health practitioners in promoting health of the local people of the Pfura rural district. Descriptive research design was used because it allowed the researchers to examine the profile, nature, practices, and challenges that traditional health practitioners are facing

4.4. The study area

As shown in Figure 1, the study was conducted in Ward **X** of the Pfura rural district community. This area is also known as Mount Darwin District of Mashonaland Central Province in Zimbabwe. Ward **X** is one of the forty wards in the Pfura rural district which is situated about 160km North-East of Harare and lies in the road that heads to Mozambique through the Mukumbura border post in the Dande Valley. The 2012 Zimbabwe National Statistics Agency estimated the population of this district to be at 228.734 (Zimbabwe Statistics, 2012), and it also projected the 2016 population at 233.442. From the projected district estimates of 2016, Ward **X** constitutes 2.7% (n=6375) of the population of thirty sub-villages. Ward **X** has only one clinic which offers primary health care to a population of 6375, with most of the patients travelling by road for a distance ranging from a maximum distance of 10-20km.

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Given the heterogeneous nature of Ward **X** villages, the study collected data from the peripheral villages which are found in the Valley of the Donga River, these include **A, B, C, D and E.** These villages share the Valley of the Donga River which is the furthest (20-25km away from the clinic) zone of the sphere of influence of the Clinic. It has an approximated overall population of 1500 people. The area is inhabited by the Kore-kore people who came from part of what is now Mozambique, with Shona as their primary language, and with a relatively high level of English literacy. The Shona people of Pfura RDC/*Nyombwe* form the North-Eastern Shona dialect called Kore-kore.

There are also other inhabitants from Malawi, Zambia and Mozambique who flocked in during the period of the Federation of Northern and Southern Rhodesia and Nyasaland. The Donga valley of Ward **X** is a first-class remote area which is characterized by poor road networks, which explains why there is poor service delivery when it comes to health. The Donga valley is known for its recent rise in the number of outstanding traditional healing practices which include herbalists, godobori/n'anga and Tsikamutanda, as well as the charm and miracle (faith healers) prophets who also have risen to fame from this area. This area is one of the areas in Ward **X** which is still culturally intact, the cultural fabric which binds beliefs, taboos and norms together is still alive. Thus, IK has survived to some extent. Moreover, the absence of road networks, exacerbated by frequent flooding rivers during the rainy season, has made villagers adopt indigenous health practices. This area is well known for its respect for the ancestral spirits, and its deep-seated beliefs in indigenous knowledge related practice.

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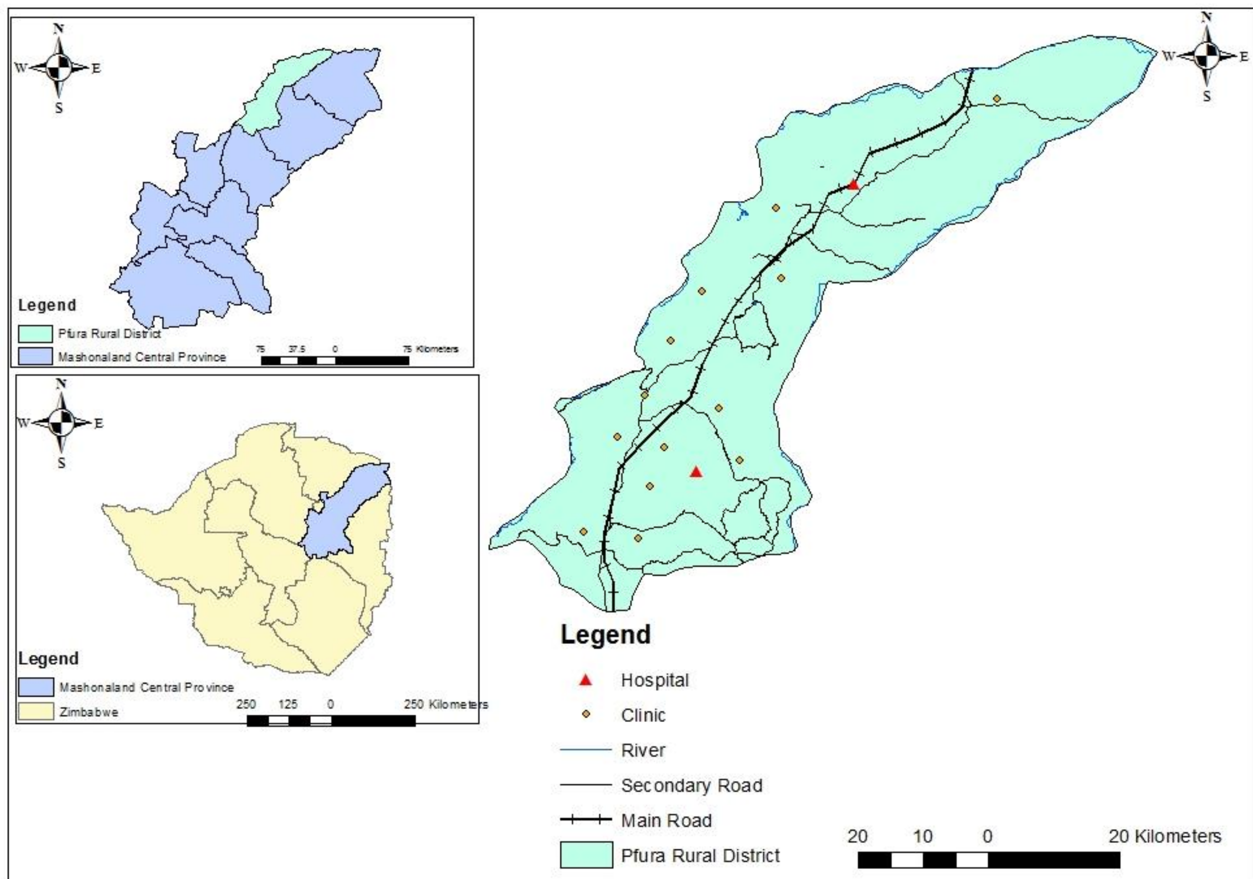

Figure 1. The Pfura Rural District Map

4.5. Study population and sample

A study population is defined as the entire aggregate of cases in which a researcher is interested, and it is therefore useful to make a distinction between the accessible and target population (Robison, 2014). The target population of this study was the registered traditional health practitioners (traditional healers/sangomas, herbalists' diviners, traditional birth attendants) in the Ward **X** of the Pfura rural district community. The total number (the register) of registered traditional health practitioner was not obtained due to some reasons which were beyond the researcher's jurisdiction, however he was referred to key and famous registered practitioners who then refereed him to other practitioners. The sample size of this study was therefore twenty-two (22) traditional health practitioners from the five villages **A, B, C, D and E** of Ward **X** of the Pfura rural district community.

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The researcher interviewed 26 participants, however, due to data saturation, 22 participants formed the sample size for the study. According to Fusch and Ness (2015), data saturation is reached when there is enough information to replicate the study when the ability to obtain additional new information has been attained, and when further coding is no longer feasible. In this study, data saturation was not about the numbers *per se*, but about the depth of the data. The saturation was reached as informed by the work of O'Reilly and Parker (2012) who attest that no new themes go hand-in-hand with no new data and no new coding, and if one has reached the point of no new data, one has also most likely reached the point of no new themes, therefore, one has reached data saturation. Moreso, in this discourse the application of triangulation (multiple sources of data) has gone a long way not only towards enhancing the reliability of results but also the attainment of data saturation.

4.6. Sampling

The present study employed non-probability sampling in the form of purposive sampling (judgmental) and snowballing (networking). Non-probability sampling is a sampling technique in which the researcher selects samples based on the subjective judgment of the researcher rather than random selection (Vehovar, Toepoel & Steinmetz, 2016). In non-probability sampling, not all members of the population have a chance of taking part in the study, unlike probability sampling, where each member of the population has a known chance of being selected. A purposive sampling method was employed in the selection of the first key informant of the study, who was a registered traditional health practitioner from **A** Village of Ward **X** of the Pfura RDC.

4.6.1 Purposive sampling and snowballing

Purposive sampling strategies are non-random ways of ensuring that categories of cases within a sampling universe are represented in the final sample of a project. This involves identifying and selecting individuals or groups of individuals that are especially knowledgeable about or experienced with a phenomenon of interest. Creswell (2013) also states that the purposive sampling technique is a type of non-probability sampling that is most effective when one needs to study a certain health domain with knowledgeable experts within. The rationale for employing a purposive strategy is that the researcher assumed, based on a prior theoretical understanding of the topic being studied, that certain categories of individuals may have a unique, different or

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important perspective on the phenomenon in question and their presence in the sample should be ensured (Robinson, 2014).

The purposive sampling technique helped the researcher to identify key informant (registered traditional health practitioners), who were particularly knowledgeable about the indigenous health practices in the Pfura rural district in Mt Darwin, Zimbabwe. The researcher, after identifying the key informant, further used the snowballing technique to identify the other twenty-one participants. The key informant chosen in the first place was a registered traditional healer and has enough knowledge about the other registered colleagues in the area.

Snow-ball sampling was used in conjunction with purposive sampling. Snowballing is a technique whereby a small number from the sample is initially selected by the researcher and then these people are asked to nominate a group or other individuals who will be prepared to be interviewed for the research (Plooy-Cillers, Davies & Bezuisenhout, 2014). The researcher purposively identified a herbalist respondent, and he suggested other registered practitioners, thus it became a chain of referral. The snowballing was adopted considering the nature of the African traditional healing which is secretive and requires a close referral. The nature of African traditional healing, particularly in Zimbabwe, is mandatory such that, for you to consult with the traditional healer you need to go through referral from close members or relatives of the practitioner. This is done to build and ensure trust and protect their indigenous knowledge. The pilot study results identified this gap of mistrust, so that is why the snowballing was used; the researcher identified close friends of the practitioner and explained the significance of the study, then he could be led into the compound of the respondent and perform all the traditional procedures which are followed by every consulting patient.

Inclusion criteria:

- Traditional Health Practitioners who are Residents of Villages of Ward **X**, Pfura Rural District Council
- Men or women
- Registered traditional health practitioners (herbalists, diviners, traditional birth attendants).

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4.7. Data collection method

4.7.1. In-depth interviews

Data collection is a systematic way of gathering information relevant to the research purpose or question (Deliens, Deforche, Bourdeaudhui & Clarys, 2014). For this study, in depth interviews were used as the method of data collection. An in-depth interview is an open-ended, discovery-oriented method to obtain detailed information about a topic from a stakeholder and its goal is to explore in depth a respondent's point of view, experiences, feelings, and perspectives (Hay, 2017). In-depth interviewing involves conducting intensive individual interviews with a small number of respondents to explore their perspectives on an idea, program or situation. In this study, in-depth interviews were conducted with key registered traditional health promotion practitioners. in-depth interviews was chosen as a method due to its suitability on the present topic which is sensitive in nature, as many traditional healing practices are regarded as sacred and complex. In addition, King, Horrocks and Brooks (2018) emphasize that in-depth interview are less formal and the least structured in nature with the wording and questions not predetermined; it is more appropriate to collect complex information with a higher proportion of opinion-based information.

In-depth interviews allowed the researcher to examine the issue under discussion at length from the interview respondent's personal perspective. The data gathered during interviews typically consisted of verbatim responses to the interviewer's questions, which were designed to elicit descriptions of personal behaviours, and the opinions, feelings, and attitudes that inform those behaviours. The primary advantage of in-depth interviews was that they provided more detailed information than what can be gathered through other data collection methods, such as quantitative surveys. In this study, they provided a more relaxed atmosphere in which to collect information. Like any research method, in-depth interviews do have limitations (Deliens et al., 2014). An important limitation is that the interviewee can construct a world, the veracity of which is usually difficult to check (of course, questionnaire surveys are not immune to this phenomenon). However, in the current instance, the interviewees felt comfortable with the interviewer, they endeavored to give what they consider to be an accurate portrayal of phenomena of traditional health practice. The snowballing technique made most of the participants comfortable, as trust was the major recipe for working together.

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4.7.2. Data collection tool (Appendix B & C)

The study adopted an interview guide which was the tool used in data collection. The central question of the interview guide was: "What is the role of traditional health practitioners in promoting health?", however, the discussion, was also guided by the specific objectives of the study as indicated on Appendix B & C. The interview guide was formulated following the research objectives and it was in both Shona and English. The researcher himself translated the interview guide to suit all participants. In the process of data collection, the participant would choose which language he/she was comfortable with, hence either one of the interview guide would be used. The interview guide involved the profile, together with the demographic information of the participants and four questions which are open-ended, including the central question.

4.7.2.1. Observation

Conroy (2017) defines observation as the systematic description of events, behaviors, and artifacts in the social setting chosen for study. Observations enable the researcher to describe existing situations using the five senses, providing a written photograph of the situation under study Participant observation therefore is the process enabling researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities. Observation allows researchers to check definitions of terms that participants use in interviews, observe events that informants may be unable or unwilling to share when doing so would be impolitic, impolite, or insensitive, and observe situations informants have described in interviews, thereby making them aware of distortions or inaccuracies in description provided by those informants. In this study observations involved the noting of behaviour of the participants like gestures, moods and description of the surrounding area. These actions and features were notes in field notes by the researcher.

4.7.3. Process of conducting an in-depth interview

The process of an in-depth interview in this study involved asking informants open-ended questions guided by the interview guide, and probing wherever it was necessary to obtain data deemed useful by the researcher. As in-depth interviewing often involves qualitative data, it is also called qualitative interviewing. The in-depth interviews were conducted in the households of the traditional health practitioners, particularly diviners and Shona language (Appendix C) was

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used during the conversations. However, with three participants who felt comfortable in using both languages, Shona and English was used. The herbalists who usually move around the villagers were interviewed at any place of their choice. Some would prefer to sit under a tree or inside their normal houses, with a few who took me to the village head kraal and we were given a room to conduct our interviews. Since the village head was central in allowing me to go around the household, it was therefore important for the participants to choose the village kraal, for ethical consideration (trust). The researcher through referral (snowballing) which was arranged prior to the meeting, would present himself or in most circumstances, he was introduced by the previous interviewee.

The researcher arrived at the household or venue where the traditional health practitioner resides and, followed cultural and traditional procedures of Kore-kore people who constitute and speak the major dialect in the Pfura rural district council. In Kore-kore tradition, to visit a traditional healer there are cultural and traditional procedures to be followed. In this study, the key informant outlines the traditional procedures which were to be followed by the researcher. Apart from a few Traditional Birth Attendants (TBAs) and herbalists, to conduct an interview with a diviner, the procedure involved the removal of one's shoes, watch and hat, and the folding up of trousers. Entering the consultation room required clapping of hands and at the same time introducing oneself, which includes one's name, totem (*mutupo*) and one's reason for the visit. It is a tradition of Kore-kore people to pay a little money (*mari yendiro*) before one speaks to a traditional healer; this is done to show respect.

This procedure made the respondents feel comfortable with the researcher's presence, thus avoiding hostility which might have limited the success of the interview. The probing was not allowed in the *nhango* of diviners however with other participants, the researcher felt comfortable to probe for more information on the subject. A *nhango* is a traditional hut which is usually built with specific type of poles and mud; its purpose is particularly for consultation. It is specifically used by a diviner or a herbalist. This hut is known a place where the diviner can communicate with the ancestors and sacrificial activities and cleansing of patients are conducted. It is very sacred as all the herbs and any related tools are kept there. Since the topic of the interview included some sensitive aspects such as ritualism and witchcraft, the researcher only guided the discussion to avoid asking sensitive subjects. The interviews lasted for 45-65 minutes. The interviews in most cases commenced with the profiling of the traditional health practitioners' biographical information, such as age, gender, educational level, marital status and other social

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aspects. The profiling also included the source of power and inspiration and training if it would apply to the traditional health practitioner in question. The profiling of traditional health practitioners was important in the sense it showed the forms in which they operate and to gain understanding of which areas of health promotion and health care do they cover.

4.8. Pre-testing the data collection tools

The term pilot study refers to a mini version of a full-scale study, as well as the specific pre-testing of a research instrument such as a questionnaire or interview schedule (Cataldi, 2018). A pilot study is also known as a pre-test, is a crucial element of a good study design, however, it does not guarantee success in the main study, but it does increase the likelihood. Pilot studies fulfil a range of important functions and can provide valuable insights for other researchers. To pretest the data collection tool, three (n=3) traditional health practitioners were interviewed in the Chivi Rural District of Masvingo Province, Zimbabwe. The major reason of the pretesting was to check the respondents o would be attuned to the topic. In addition to the preliminary and exploratory phases of the research survey for pretest, the pretest assisted the researcher to familiarize himself with the topic and participants.

The researcher, with aid of Chivi Health Council Officers, was provided with the phone number and addresses of the traditional health practitioners. The interview sessions were pre-arranged a day before through the telephone for permission, and the appointment was set. The three sessions lasted between 35-55 minutes each. All the respondents were males, which included two herbalists and one diviner, with ages ranging from 55-70 years old, who have been in the practice for over three decades. The pretest of the interview informed the researcher that organizing interview sessions with traditional health practitioners is tricky and difficult as they appeared to be not aware of modern research activities. In this regard, the researcher observed and noticed that, with little knowledge, traditional healers related the researcher to the Christian based media which despise the traditional practice as heathen, thus the adoption of the snowballing which ascertained the relationship and understanding between the investigator and the respondent.

In addition to pre-arrangement, many of the traditional practitioners are in business, therefore whenever they receive a call for an appointment, what comes to their mind was that consultation always comes with money. The pretest however informed the researcher that it is very necessary

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for the actual data collection for the researcher to seek the use of a local negotiator/research assistant to have a fruitful and smooth in-depth interview. The pretest indicated that before the interviews the respondents need to have trust and feel secure in as much as his/her giving information is concerned which is then addressed on the section ethical consideration in this study.

The researcher noticed that one of the respondents who was a diviner felt that his responses would be used for other different purpose that may jeopardize his practice. To overcome the respondent's misperception about the interview, the investigator called the previous interviewees who were herbalists and they happen to understand and knew each other, that's when he agreed to be interviewed. In summation, the participants were information-rich as they revealed a good understanding of the topic by giving marvelous detailed accounts of their experiences. The investigator was also informed that it is imperative to have a local and known research assistant who can facilitate the interview together with the researcher to avoid suspicion and mistrust thus the actual study adopted snowballing strategy.

4.9. Data analysis and management

Like most types of research, the amount of analysis required varies with the purpose of the research, the complexity of the research design, and the extent to which conclusions can be reached easily based on analyses. Analysis is to make sense of the findings. The most common analyses of in-depth interviews results involve a transcript of the discussion and a summary of the conclusions that can be drawn. Creswell (2015) states that data analysis involves making sense out of text and image, moving deeper and deeper into understanding the data, representing the data and making interpretation of the larger meaning of the data. Data analysis, organization, and interpretation, was done using Tesch's method of data analysis for qualitative research.

According to Braun et al. (2019), thematic analysis is historically a conventional practice in qualitative research which involves searching through data to identify any recurrent patterns. A theme is a cluster of linked categories conveying similar meanings and usually emerge through the inductive analytic process which characterizes the qualitative paradigm. Initially the interviews which were done using Shona language were translated into English with the help of a University of Venda student (Shona speaking) in the Department of Languages. The demography of the participants which summarized the profile of the traditional health practitioners was quantified

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using the Statistical Package for Social Scientists (SPSS version 23.0), and presented in tables and charts.

The supplementary data (verbatim) was presented, without any attempt by the researcher to correct the grammatical errors, and is coded to facilitate audit trailing. The researcher has listened to audiotapes and transcribed them, and has also read field notes and the transcripts were re-read, to get a universal understanding of the interviews and to familiarize himself with the data. Thereafter, the researcher randomly picked each verbatim transcript, and started analyzing them one by one, until all the transcripts had been analyzed and similar ideas or topics had been coded. After coding, similar topics were grouped together into categories. From each category, several themes also emerged with subsequent sub-themes.

4.9.2. Tesch's 8 Steps of thematic method of data analysis by Creswell (2013).

Step 1: Familiarization and preparation of data: The researcher read all the field notes and listened to audio recordings and jotted them down. All the data collected was translated to English and transcribed. It was important that the researcher was able to understand the content of the interview and all aspects of the data. This step offered the foundation for the subsequent analysis.

Step 2: One document (one interview transcript), was picked and browsed. Understanding the text and what it is all about.

Step 3: After engaging several participants' transcripts, a list of all topics was made and similar unique and major topics were clustered, codes were written on the segments of each transcript. A code was labeled and attached to a phrase or other short sequence of the text. The identified preliminary codes, were the features of the data that appear interesting and meaningful as well as more numerous and specific than themes, but provided an indication of the context of the conversation.

Step 4: Generating themes: The researcher found the most descriptive wording for the topics and turn these into themes. Themes differ from codes in that themes are phrases or sentences that identify what the data means. They describe an outcome of coding for analytic reflection. Themes consist of ideas and descriptions within a culture that can be used to explain causal events, statements, and morals derived from the participants' stories. In subsequent phases, it is important to narrow down the potential themes to provide an overreaching theme. Thematic

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analysis allows for categories or themes to emerge from the data like the following: repeating ideas; indigenous terms, metaphors and analogies; shifts in topic; and similarities and differences of participants' linguistic expression.

Step 5: Defining and naming themes: This step involved refining and defining the themes and potential subthemes within the data. Ongoing analysis on this step further enhanced the identified themes. The researcher provided theme names and cleared working definitions that captured the essence of each theme in a concise and punchy manner.

Step 6: Assessing the consistency of coding employed: After coding the whole data set validity and reliability was checked.

Step 7: Drawing inferences based on coding or themes: In this step, the researcher draws inferences based on codes and themes generated. The importance was to explore the properties, and dimensions and identify the relationship and uncover patterns to present the analysis.

Step 8: Report writing: The write-up provided sufficient evidence (verbatim) of the themes within the data and was presented sequentially following the specific objectives of the study. After final themes have been reviewed, researchers begin the process of writing the final report. While writing the final report, researchers decide on themes that made meaningful contributions to answering research questions.

4.10. Measurement to ensure trustworthiness

In the 1980s, Guba and Lincoln transformed the nature of qualitative inquiry by developing criteria to ensure rigor (which they termed trustworthiness) during qualitative inquiry, to evaluate the credibility, transferability, dependability and the conformability of the findings (Morse, 2015). Guba and Lincoln (1982) argue that trustworthiness refers to the extent to which research findings are worth giving attention to and worth taking note of as well as the issue of whether the reader is convinced that the findings are to be trusted. To ensure the trustworthiness and rigor of qualitative findings, the researcher considered dependability, credibility, transferability and conformability as trustworthiness criteria (Lincoln, & Guba, 2007).

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4.10.1. Credibility

Credibility is defined as the confidence that can be placed in the truth of the research findings. Anney (2014) observes that credibility establishes whether the research findings represent plausible information drawn from the participants' original data and is a correct interpretation of the participants' original views. This study established rigor of the inquiry by adopting the following credibility strategies that include the use of verbatim, prolonged and varied field experience, time sampling, reflexivity (field journal), triangulation, member checking, peer examination, interview technique, establishing authority of researcher and structural coherence. Each strategy is discussed in detail in the sub-sections below.

4.10.1.1. Prolonged Engagement in Field

According to Anney (2014), qualitative research data collection requires the researcher to immerse him or herself in the participants' world. This helps the researcher to gain an insight into the context of the study and minimizes the distortions of information that might arise due to the presence of the researcher in the field. The researcher has been in the research site and interacting with traditional health practitioners in the villages for a period closer to a month in order to improve the trust of the respondents and it gave a greater understanding of participants' culture and context. Furthermore, the purposes of the early familiarity with the patterns of traditional healing in Pfura was to gain understanding of the role of traditional healing in promoting health in a rural setting. Prior to data collection, the engagement and familiarizations was done with traditional health practitioners and community members was done after the research has read a lot of published work on the subject topic. Seidman (2012) argues that the extended period is important because as rapport increases, informants may volunteer different and often more sensitive information will be exposed than they would have done at the beginning of the research. Thus, prolonged engagement in the fieldwork helped the researcher to understand the core issues that might affect the quality of the data because it helps to develop trust with study participants.

4.10.2. Triangulation

Triangulation induces the use of multiple and different methods, investigators, sources and theories to obtain corroborating evidence (Hussein, 2015). Triangulation helps the investigator to reduce bias and it cross examines the integrity of participants' responses. There are three major

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triangulation techniques. The first is investigator triangulation that uses multiple researchers to investigate the same problem which brings different perceptions of the inquiry and helps to strengthen the integrity of the findings (Anney, 2014). The second which was adopted for this study is data triangulation wherein the audio recorder and field notes were used. Field notes are defined as qualitative notes which are recorded by scientists or researchers in the course of field research, during, or after observation of a specific phenomenon they are studying, the account include things like the researcher's, experiences, feelings and thought (Blomberg et al., 2017).

The study adopted two types of field notes which were descriptive/observational notes and analytical notes (Taylor, Bogman & De Vault, 2015). Descriptive notes are the factual data (through verbal and non-verbal techniques) that was being recorded, and in this study the factual data notes included time, date, the state of the physical setting, social environment and descriptions of the subjects being and their roles in the setting. The reflective notes were based on the observers/ researcher reflections of the observation. With reflection notes the researcher reviewed on the strategies of which were used as observation skills, to verify the success and failures of each.

4.10.3. Peer debriefing

Morse (2015) attests that peer debriefing involves meeting by the inquirer with a disinterested peer (someone who is willing to ask probing questions but who is not a participant in the setting where the study is being conducted) in which the peer can question the methods, emerging conclusions, biases and so on of the inquirer. The debriefing was done prior data collection and assisted the researcher as he was collecting data from indigenous health practitioners from whom social and cultural ethics are of concern especially when conducting a study.

The peer who happened to be a PhD student (qualitative study expert), interrogated the researcher on the aspect of conducting an in-depth interview. The outcome of the debriefing indicated that the investigator needs to sharpen his skills of interviewing as the success of the study depended a great deal upon rapport and relationships established with participants in the field. A peer debriefing helped the researcher in considering and weighing alternative responses to sensitive situations and thus potentially refiguring subsequent steps in interviewing. The debriefing assisted the investigator in the choice of words when interviewing elderly and at the

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same time traditional health practitioners. It was noted during the debriefing session that probing questions should not be in an interrogating manner.

4.10.4 Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts or situations with other researchers and it is the interpretive equivalent of generalizability (Brinkmann, 2014). The researcher ensured the transferability of the study findings through thick description, snowball and purposive sampling (Anney, 2014). The researcher provided a detailed description of the enquiry and participants were selected purposively, it facilitates transferability of the inquiry. According to Li (2004), thick description enables judgments about how well the research context fits other contexts. For the purpose of this study, a rich and extensive set of details concerning methodology and context were provided in the research report and it included all the research processes, from data collection, context of the study to the production of the final report (as shown in chapters 1, 2 &4). All the experiences in the study field are detailed and it allows the replication of the study findings to be of similar conditions in other settings. As indicated previously, purposive and snowball sampling methods were used to guarantee the transferability of the study findings. Moreso, the generalization through categories and themes and the description of the study site and participants also ensured transferability.

4.10.5. Dependability

Dependability refers to the stability of findings over time and it involves the investigator evaluating the findings and the interpretation and recommendations of the study to make sure that they are all supported by the data received from the informants of the study (Cohen, Manion & Morrison, 2011). In this study, dependability of the findings was established through a code recode approach. The researcher conducted a code-recode procedure on his data throughout the analysis phase of the study. The code-recode strategy involved the coding of the same data twice and it was two weeks' gestation period between each coding. The results from the two coding (using Tecsh's steps) were compared to see if the results are the same or different. The code recode strategy is also referred to as code agreement, it was a process which allowed multiple observations and adjustment and editions were made. The adjustments were done by removing codes and verbatims which were similar and collating them with old ones.

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4.10.6. Conformability

Confirmability refers to the degree to which the results of an inquiry could be confirmed or corroborated by other researchers (Cohen et al., 2011). Confirmability is concerned with establishing that data and interpretations of the findings are not figments of the inquirer's imagination but are clearly derived from the data. In this study, confirmability of qualitative inquiry was achieved through an audit trail and reflexive journal. Henry (2015) posits that an audit trail involves an examination of the inquiry process and product to validating the data, the researcher accounted all the research decisions and activities to show how the data was collected, recorded and analyzed. In this study, trail of evidence included notes about data collection experiences, documentation of changes in design (as recommended by the pilot test), the researcher's experience in the conduct of the study, and memos generated during data analysis. The field notes composed of the researcher's observations of a setting during a data collection, including notes about the context of a data collection episode. The audit trail enabled the researcher to reconstruct the steps of the study and later provide justification for any changes that took place as cited in the work of Hadi and Closs (2016).

A reflexive journal which provided a means to keep track of the researcher's thought processes during the study. Meyers and Willis (2018) attest that the work of data analysis in qualitative research relies heavily on the cognitive processes of the researcher, the ability to document these processes and capture the researcher's own insights, interpretations, and reactions can be beneficial to the analysis process. Transcript documents and audio recordings were kept for crosschecking the inquiry process, raw data, interview and observation notes, records collected from the field and others thus ensuring confirmability. The researcher reflexive journal, which included all events that happened in the field, personal reflections in relation to the study, such as the phenomenon that arises during the investigation were secured.

4.11. Ethical considerations

Ethics are concerns, dilemmas and conflicts that arise over the proper way to conduct research. Research ethics involves protecting the rights of respondents and institutions in which research is done and maintaining scientific integrity. A researcher is responsible for conducting research in an ethical manner and failure to do so undermines the scientific process and might have negative consequences. An investigator must address a range of ethical issues especially when a study

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involves human beings and these issues include, permission of data collection, prior informed consent, right to refuse to participate. The research proposal was presented to the School Higher Degrees Committee (SHSDC) of the School of Human and Social Sciences and to the University Higher Degrees Committee (UHDC) at the University of Venda for recommendation and approval by the University Research Ethics Committee. The ethical clearance **(Appendix F-Project No. SHSS/18/AS/01/1403**) was then presented to the Pfura Rural District Medical Director of Mt Darwin Hospital who gave the permission (**Appendix G**) to access the respondents in villages of Ward **X**.

4.11.1. Informed consent and voluntary participation

Prior consent forms together with information sheets which written in Shona and English were given to each participant to read, understand and sign. The researcher ensured that all the essential information such as purpose of the study and significance of the study, as well as voluntary participation is provided on consent forms to enable the participants to make an informed decision before signing the form. Participants were informed that they have the full right to refuse participating in the research (they can choose not to respond to some or all questions) and participants that do wish to withdraw their participation can do so at any time. To herbalists who were not diviners, to ensure confidentiality, interviews were conducted at places of their choice where they felt comfortable since they did not have their specific traditional healing palace (*nhango*).

4.11.2. Confidentiality and anonymity

The researcher agreed to maintain confidentiality by not divulging any personal information given by the participants only in circumstances that the information was to be shared. The confidentiality ensured and the information with regards to it was on the consent form. The respondents' sensitive and personal information was protected and was not given to any other person nor used by anyone else other than the researcher. This enabled the participants to speak freely. The participants were told that the information collected for this research project will be kept confidential. Data provided by participants is kept under lock and key and will not to be made available or divulged to any other person and it will be destroyed after the study is published. The researcher explained that information the participants provided cannot be identifiable by both the facilitator and the investigator because it would not have names or any other identification on it.

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The researcher labeled and gave every interview conducted, a numerical code number. The name of the Ward and villages were labeled with letters of the alphabet i.e. A, B C, D, E, etc.

4.12. Limitations of the study

Even though the study explored the role of traditional health practitioners in promoting health, a number of limitations should be acknowledged. The selection of a qualitative methodology was entirely appropriate for this study; however, its application was not without limitations. The researcher assumed that the sample of this study was small, not randomly selected and located in a single geographical location. The small number of traditional health practitioners targeted in this study was because there is no known proper record to identify the registered traditional practitioners with exact location. The absents of a well-defined register of traditional healers became a setback slackening down the process of data collection, since the researcher had to rely on chain of referral through snowballing.

Intellectual property issues and suspicion among practitioners has been one of the limitation. This was observed during the data collection when some of the respondents did not want to participate for the fear that their knowledge would be stolen and used for other purposes of no benefit to them. To decrease this limitation, the researcher had to give detailed discussion about the purpose of the study. As it was enough, traditional and prohibitive traditional and cultural norms in the Kore-kore did not spare this study, in some few cases the respondents particularly the diviners, did not want a recorder in their consultation rooms. The research therefore relied on field noting, which he feels was a challenge since it is difficult to jot word-to-word, as well as memorizing the whole interview. Despite the technical limitations, the findings of this study remain vital and used for comparison to other geographical locations and populations.

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CHAPTER FIVE

Results and Interpretation

5.1. Introduction

The present study was conducted to explore the role of traditional health practitioners in health promotion in the Pfura Rural District Council (RDC), Ward **X.** This chapter therefore presents and interprets the study findings which were collected from twenty-two (N=22) in-depth interviews conducted among both female and male traditional health practitioners of the Pfura District Council, Ward **X**, Mt Darwin, Zimbabwe. The study findings are presented in sections, which are based on research objectives: the traditional health practitioner's profile, traditional health promotion practices, challenges facing the practice and practitioners, as well as the strategies and guidelines for an enhancement of good and quality health promotion practice in a rural setting. The study findings are presented in themes and subthemes wherein verbatim quotes will be used to support the emerged study themes.

5.2. Profile of traditional health practitioners in the Pfura Rural District, Ward X

The study objective (1) focused on profiling the traditional health practitioners (THPs) in the Pfura Rural District Council, Ward **X** in Zimbabwe, Mashonaland Province. The profiling generally focused on the demography of the research participants. However, factors like the type of traditional health practice, the average number of consultations, spheres of influence and sources of power also became an important entity of this objective. The profile of traditional health practitioners (THPs) as shown in this study, revealed how long the traditional health promotion practice has lived, and its role in the local people's health care, as well as its role in assisting the current dilapidating conventional/modern health system. The following two sub-sections will present and interpret the profile and the characteristics of the twenty-two-traditional health practitioners who participated in the study.

5.2.1: Demographic information of the respondents (N=22)

The present study was conducted in a rural setting, wherein twenty-two traditional health practitioners participated in the study. **Table 1** indicates the age, gender, residence, source of knowledge/power and number of years of experience of the study respondents. The study

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participants were dominated by the older people (75-100 years), who constituted the majority as 50% (n=11). Out of the 22 participants, most (n=12;54.5%) of them were males however the total number (n=10;45.5%) of women respondents was considerate. The data for the present study was collected from five villages in the Pfura Rural district, Ward **X**, under Chief (*mambo*) Dotito with an even representation of interviewees from each village except the **A** village which has 27.3% (n=6) in respondents. Many (81.8%; n=18) of the study participants revealed that for them to perform traditional health practices, they got knowledge from *vaMwari/Vadzimu* (Ancestral Spirit) and very few (18.2%; n=4) said they practice due to mentorship they have received from other traditional health practitioners.

Table 1. Demographic characteristics of respondents (N=22).

Characteristics	Frequency (N=22)	Percentage (%)
Age		
25-55 years	03	13.6%
56-75 years	08	36.4%
75-100 years	11	50%
Gender.		
Female	10	45.5%
Male	12	54.5%
Village of residence (Ward X)		
A	06	27.3%
B	03	13.6%
C	04	18.2%
D	05	22.7%
E	04	18.2%
Source of power/knowledge		
Mentorship	04	18.2%
Ancestral Spirit (*mudzimu*)	18	81.8%
Years of experience/service in THP		
4-40 years	08	36.4%
41-60 years	14	63.6%

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As the larger (81.8; n=18) group practices with the ancestral spirit/*vadzimu*, the study revealed that the calling of traditional healer runs within tribal families and is practised for the benefit and protection of tribal clans (*madzinza*) and the community. It was established that traditional healers inherit their spiritual gifts and skills from either or both sides of their paternal or maternal ancestral lineages. To keep in good relationship and proclaim the work with these ancestral spirits, the traditional healers attested that they periodically make sacrifices and offerings to those spirits. In supporting the idea of source of knowledge, the verbatim documentation below revealed that, not only traditional healers use the power from ancestral spirit; some of these spirits were believed to be having a link to certain wild animals. The study revealed that most of the participants were having spirits of either a mermaid (*shave renjuzu*), spirit of a baboon (*shave regudo*) and the *mhondoro* spirit (tribal lion spirit). A participant member articulated;

> *It was in 1933 when I was doing standard one , I think I was also 10 years old, I then went to Machiri a nearby pool with a waterfall and this place we grow up being told that its sacred (yaiera) but you know as young people I wanted to prove and see how the pool look like, going there that was then, I was taken (some mysterious creature splashed water to my face and was got confused and numb , I only remember that I was in an underwater world) by the mermaid for six months. As my parents was aware of it when I was back they organized traditional ceremony, and that's when I started to become a traditional healer.* (Participant 5)

Although few traditional practitioners, especially the herbalists and traditional birth attendants, indicated that they practiced through mentorship as source of knowledge and zeal, the study findings show that the mentors were traditional health practitioners who had an ancestral spirit. These mentors provided them an apprenticeship which teaches a future practitioner how to identify, prepare and use traditional herbs, a system for diagnosing and treating illness, and lessons in cultural and social practices. The mentorship was given through ceremonies where knowledge is revealed as a gift. A male herbalist supported mentorship that in the Kore-kore tribe, most people became practitioners as they have served as assistants (*katenaire*) to the established traditional practitioners. While general knowledge of the healing properties of medicinal plants may be widespread in Kore-kore, only a select group of trained practitioners know exactly how herbs are used in the traditional system. Two participants, who were certified herbalists who both indicated that they practice indigenous health, concurred on the following;

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> *In our Korekore culture it is our tradition that there is supposed to be one in a family who assists sekuru (the spirit) this person is called katenaire (a person who run errands/ right hand man of a traditional healer).* (Participants 12)

Another participant member claimed,

> *I was born to a father who was a traditional health of this land (mhondoro) and my mother a Malawian born had a spirit of a mermaid (shave renjuzu), because of their old age, they had issue in travelling to the bushes to fetch the herbs or animal products so it was then my duty to run around, through all that I was nurtured to an extend that I can even administer any herb to a patient, only I couldn't do divination.* (Participant 3)

The study data was collected from well experienced traditional health practitioners as it was indicated by their years of experiences, with the majority (63.6%/n=14) revealed that they have been practicing for a period between 41-60 years, however only eight (36.4%) indicated that they have been in the service for a period between 4-40 years. In terms of level of education, only three herbalists have revealed that they have attended tertiary school, but the majority did not attend school, some giving reasons that their ancestral spirits didn't allow education and other said the Zimbabwe liberation struggle denied them an opportunity to study.

5.2.2: Types of THPs in Pfura and the frequency of consulting patients

The study collected data from three different types of traditional health practitioners who included diviners *(vavuki)*, herbalist *(godobori)* and traditional birth attendants (TBA)/*nyamukuta*/village health workers. The study results revealed that it is very rare to separate many traditional health practices from divination, therefore it was discovered that only the minority of study participants practised herbalism and birth attending without divination powers. The study participants revealed their roles wherein the diviner said their duty it is to make a diagnosis, prescribes and treats ailments. Six participants established that they have knowledge of herbs, roots, and even fruits that can prevent, protect, or cure diseases and pain. Most (n=18) of the respondents confirmed that they practice more than two practices which included divination, herbalism and traditional birth attending.

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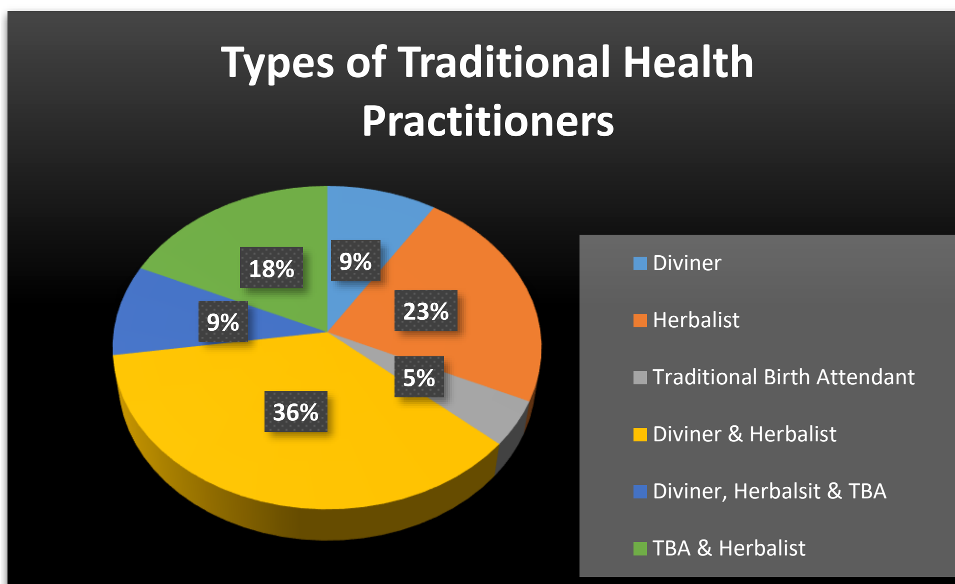
The study further established that the diviners in the Pfura Rural district are of the Kore-kore tribe, which consist of two types of diviners; the one who uses or throws *hakata* (bones) and the one who is possessed by an ancestral spirit (*mudzimu*). The bone throwers revealed that when they throw the bones/*hakata* it then answers or explains the problem in question, whilst the possessed diviners, will get possessed by an ancestral spirit and start to behave as if they are in trance or hypnotic state. The ancestral spirit as indicated earlier on was revealed to be either manifest as a dead kinsman or as a spiritual animal. In the Pfura Rural District, Ward **X** the traditional birth attendants (*nyamukuta*) indicated that they are no longer much involved in assisting deliveries but they are working as community health workers who only escort and assist in an emergency.

The traditional birth attendants indicated that home deliveries for pregnant women is discouraged by the ministry of health and child welfare due to the high rate of HIV and some malpractices which resulted in high numbers of maternal deaths and accidents. They then outlined that they only work as health promoters, whose duty is to encourage and escort pregnant women to visit the clinic and to keep the documentation of pregnant women which they report to the clinics. **Figure 2** shows that most of practitioners are diviners. 36% (n=36) haves shown that they are both diviners and herbalists, 23 % (n=5) are herbalists, 18% (n=4) are both a TBA and herbalist, 9% (n=2) are diviner herbalist and TBA consecutively, and 5% (n=1) of diver and herbalist.

Figure 2: Types of Traditional Health Practitioners



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5.2.3.: Average number of patients consulting with THPPs per week in the Pfura RDC, Ward X.

Table 2 shows the frequency of patients visiting/consulting with the traditional health practitioners in the Pfura rural district, ward **X.** It clearly shows that most of the respondents in the study are receiving more than sixteen patients per week. The other seven participants of the study indicated and that they received patients from 1-15 per week which is a great number considering the present of conventional health system in the Pfura Rural District Council.

Table 2: Number of patient consultations with Traditional Health Practitioners in the Pfura RDC, Ward X.

Number of participants	Percentage/proportion of participants (%)	Number of patients received per week
1	4.5	1-5
3	13.6	6-10
3	13.6	11-15
15	68.2	16 and above
22	**100**	**Total**

5.3: Traditional health promotion practices in the Pfura RDC.

This section presents the different traditional health promotion practices that are found in ward **X** in the Pfura Rural District Council. Twenty-two in depth interviews were conducted, addressing the second objective of the study, the main themes and subthemes emerged are summarized in Table 3. The traditional practitioners interviewed established that they use various methods and techniques such as divination, cleansing rituals, protective amulets, and herbs to cure and heal. The diviners indicated that for instance, if the sickness is supernaturally caused, then they use rituals together with herbal remedies. In diagnosing the sick patient in the traditional health

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practice the study established that dreams also carry a whole range of significance in the traditional healing practices as they interpret dreams and use the gathered knowledge towards healing.

Table 3: Summary of categories, themes and subthemes.

Categories	Main themes	Sub-themes
Traditional health promotion practices	Promotive and preventative indigenous health practices	○ Use of protective amulets, charms and traditional ornaments that promotes health ○ Traditional love portion and the promotion of fidelity and health ○ Traditional health promotion and the reproductive health ○ Norms and taboos in Pfura RDC and health promotion ○ Indigenous health disaster forecasting and rain making ceremonies
	Curative health practices	○ Traditional treatment of diseases and illnesses ○ Diagnosis of illness and problems in the traditional health system. ○ Referral of patients within the traditional health system
	Herbalism, Christianity, and witchcraft in traditional health promotion	○ Traditional healing and witchcraft ○ The influence of Christianity on the African culture and tradition
Challenges facing traditional health promotion practice	Challenges facing the practitioners	○ Traditional health practice has low income ○ Poor professional development ○ Age of practitioners and the future of traditional health practices
	Challenges facing the traditional health practice	○ Lack of consultation facilities ○ Extinction of herbal and medicinal products ○ Nonexistence of research and scientific assistance ○ Poor and false documentation of traditional health practices

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Strategies for enhancing rural traditional health promotion	Policy framework	○ A review and codification policies that govern traditional health practices ○ Internationalization and commercialization of traditional health practices ○ Multi-sectorial approach to traditional health promotion ○ Traditional health conservation sanctuaries and training schools
	Integration	○ Integration of the traditional medicine and modern health promotion practices ○ Integrating traditional health system with medical research institutes

5.4 Theme 1: Preventative and promotive traditional health practices in the Pfura RDC

The present study on the role of traditional health practitioners in promoting health has revealed interesting activities that promote health for all in a rural setting. The study revealed that most of the activities/ practices in Pfura are either preventative, or promotive or both in nature. The sub-themes support the same notion. The yielded data by this study offer strong and convincing evidence that traditional promotive and preventative practices identified, cuts across all health issues and concerns of person's general wellness and spiritual wellness.

5.4.1. Subtheme 1: Use of protective charms and talisman and traditional ornaments

The study identified the use of amulets/talisman/charms which widely known in Kore-kore as *zango or chuma*. This *chuma/*amulet will be made up of roots or several types of roots and various other items such as pieces of animal bones, skin, stones, and feathers. All these constituents are stitched up in a piece of cloth which might be in white, black, red and any bright colour and stitched up by a string then it will be worn around the neck, waist, or wrist as a protection against any diseases or an evil spirit. The research participants emphasized that the amulets/*zango* are only designed to protect a person from diseases and ward off evil spirits but it is also believed to confer or increase certain benefits such as prosperity in business and agriculture as articulated by a female diviner:

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When a child is growing, he or she is vulnerable to certain diseases or evil spirits (mamhepo) we then use zango/chuma which is worn for a given period as the spirit instructs, even adults with different health problems especially spiritual attacks and bad lucky a zango is used as a preventative measure. (Participant 14)

The disease or any evil spirit will find you prepared when you wear the amulet every time. (participant 18)

In a traditional preventative approach, the study found the use of *chifumuro* plant/*dicoma anomala(botanical name)* plant which is usually used as a charm against allergies and fontanelle/*chipande/nhova* in new born babies. *Chifumuro* in Shona language means to "expose" and in Kore-kore tribe of Pfura it was indicated that it has the connotation of "exposing" to shame (*kufumura)*. The underlying conviction in the use of this plant (*chifumuro*) is that it will expose the nature of the illness and disease and neutralize its effects upon the patient. This exposure is believed to further restrict the aggressive nature of the illness so that it is effectively prevented from attacking any member in the family. A traditional birth attendant who identified herself as an herbalist too, also emphasized that although *chifumuro* is limited to a specific disease, it acts as a safeguard against illness in children. She further indicated that rheumatism (*chitsinga*) was one of the health problems that she had been managing and preventing and she mentioned that *chitsinga* was believed to be caused by evil spirits:

For chitsinga (rheumatism) and other complex physical disorders ……caused by sorcerers, the Kore-kore traditional practitioners of Pfura we recommend the use of the mutara/gummy gardenia tree's small bark which is put in the patients hair when they go to sleep, or patched on the upper part of the door entrance. The aim is to affect the psyche of the witches who may have the person on the 'hit-list'. The effect of this mutara is a strategy to make the witches stupid or forget bewitching the person who uses this herbal-protective device. (Participant 22).

5.4.2. Subtheme 2: Traditional love portion for the promotion of fidelity

The study showed that as many marriages are breaking because of a high rate of infidelity which comes with a lot of adverse effects which could be in the form of diseases like *mukondombera*/HIV/AIDS and several venereal diseases, the practitioners suggested to offer a charm called *mupfuhwira* (love portion). One of the traditional birth attendants cum diviner and a

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herbalist (participant 4) revealed that the charm is normally mixed with the food of the husband and the belief is that the portion will divert husband's entire attention to his matrimonial wife:

> *I take a lizard/chipota nemadziro (chipota nemadziro-literally meaning something that goes around the wall) and kill it and burn into powder then this powder I give to a female client to mix with the relish (meat) prepared for the meal of her husband*. (Participant 18).

As a precautionary measure the study participants particularly the diviners shared the same opinion as they indicated that some of the charms for preventing infidelity are dangerous and unhygienic practices like the mixture of pubic hair, blood from the vagina, saliva and mucus therefore, precautionary measures should be in place. Furthermore, some of the love portion charms were reported to be of great danger as husbands may develop a psychological disorder;

> *The food with the charm, the wife (client) should test it before giving the husband, and some herbs which are mixed with, are to be kept outside the yard overnight, we do know the secret of what to observe the following morning to authorize the charm.* (Participants 16)

5.4.3. Subtheme 3: The traditional health practices and the promotion of reproductive health

The study identified a severe disease called *musana (means the backbone)* which affects both male and female. Translated and taken literally, it may mean one is suffering from backache, however in the Kore-kore tribe, the rich symbolism is alluding to problems of impotency and infertility. For females with child-bearing problems the answer lies with the diviner or herbalist's *kuuchika* (restoring fertility) whereby, the women are given herbs so that conception is possible. An excellent alternative form of herbal treatment, *ruvande* was reported to be fruitful. As for men, it was revealed that there are many aphrodisiacs at their disposal, called colloquially *vhuka-vhuka* (wake-wake) a dietary supplement with hooves of a bull (*mazondo*) being used with the roots of *munhengeni*/sourplum:

> *The mazondo are cooked and the mixture is taken with sadza/soft porridge at once before one takes a woman to bed. This process is called kusimbisa musana that means, increasing sperm production, simultaneously strengthening the sperms, and*

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activating the organs, like a bull, hence, the appropriateness of mazondo and the sexual stimulant vhuka-vhuka. This is prompted by the fact that failure to have children is sometimes attributed to socio-moral factors or spiritual forces that weaken the male sperms and render the victim impotent. (Participant 19)

Three participants (9;20;12) shared a sentiment and testified that they have successfully assisted women and men who had problems of infertility/ hwungomwa. One of them reported that infertility/hwungomwa is in some cases caused by vaginal growths called *sare* which are skin tags and polyps found in vaginal area. *Sare* is believed to cause miscarriages in women and death of healthy born children. The participant 8 who was a woman, argued that in Kore-kore culture when a married couple does not conceive the blame is usually given to women, hence he has a lot of women consulting on infertility issues:

Cutting of Sare or vaginal growth is not done any how; you need to be well experienced but for myself I cut it without any complication so far given that I received medical training some time ago. Not only do I cut it, I can rub some powders which are secretly mixed then the growth will disappear, I do have living testimonies to this. (Participant 8).

5.4.4. Subtheme 4: Norms and taboos in the Pfura Rural community health promotion.

The study participants revealed how important taboos (*zviera-era*) and norms (*mirao*) have assisted in the sustainability of traditional health practice in the Pfura rural villages from time immemorial. However, with time, the respondents blamed Christianity and civilization attesting that the taboos to some extent have lost value over the protection of indigenous health promotion. The traditional health taboos which used to be in the Pfura community revealed a strong idea and effect in preventing illnesses and disease as well as in protecting and promoting the wellbeing of the indigenous people. The taboos were grouped into sexual, environment and food taboos which govern their society.

All the participants across all the areas of practice (divination, herbalism, TBA) acknowledged the contribution of taboos and norms in making the indigenous health practices to be acceptable to the present world. The taboos were reported to be sustaining the indigenous knowledge system for posterity. The study respondents further clearly illustrate the meaning of the taboos to the Kore-kore culture in relation to their cultural preservation. Participants 4 and 8 who were diviners,

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indicated that the traditional taboos among the Kore-kore people of the Pfura RDC, were there to safeguard the environment which gives them life, which included the mountains, rivers, animals, and trees. The study established that zviera-era was central to the protection of Pfura culture wherein health practices are enshrined, therefore, it was of great importance to adhere to these cultural rules of the land (*mirao yedunhu*)

> *In this area we have trees which are sacred, you can't use them for fire wood, for example it is a taboo to use an indigenous fruit tree like munhunguru/govenors plum as fire wood or any domestic use.., like I have said it before thet our life comes from the surrounding, so we have to protect in whichever way. For example, areas like Zvingwiru pool you cannot bath with soup or wash dishes it is a taboo…... Here taboos are still being observed with a majority, although few like the ones who once migrated to town are now having a new interpretation.* (Participant 8).

The majority of diviners with more than forty years of practice, concurred that taboos are still useful and have any effect among the Pfura community, they gave the detailed explanation of certain forbidden practices that promote health. The study revealed that traditional taboos have an effect on the adherence on a certain health promoting practice, however within the minority subjects, it was also revealed that modernization has challenged it. Zviera era/taboos in the Pfura Kore-kore tribe are taught to kids/ the young generation so that it grows with them and for posterity:

> *Kids we taught them not to do body viewing during funerals, or even to attend a funeral also though few still go with them. At a funeral, people will be sobbing and morning which can also make the kids psychologically ill. Therefore, in this regard we are protecting the emotional wellbeing of the bereaved. And despite a recent rise in early marriages here in Pfura it is a taboo for child to gate married before the age of eighteen as it is belied that the mother will have a lower back pain. In other sense this will help our youths to fully develop physically and psychologically, women for example they won't have reproductive problems during pregnancy.* (Participant 19)

A traditional birth attendant, whom also said that she is a catholic concurred by giving understanding that the taboos were not only found to Kore-kore culture, but also in the Bible. The participant 2 reported that,

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some people they sometime shun this taboos, but with me. The bible says in Leviticus chapter 12 verses 2-5. (Participant 2)

"The lord said to Moses, "Say to the Israelites: 'A woman who becomes pregnant and gives birth to a son will be ceremonially unclean for seven days, just as she is unclean during her monthly period. On the eighth day, the boy is to be circumcised. Then the woman must wait thirty-three days to be purified from her bleeding. She must not touch anything sacred or go to the sanctuary until the days of her purification are over. If she gives birth to a daughter, for two weeks the woman will be unclean, as during her period. Then she must wait sixty-six days to be purified from her bleeding" (Prasheeba & Rose, 2019).

The scripture even supports our taboo that says a woman after birth she will abstain from sex for three months and she is not allowed to prepare food and other household chores. There is a belief that if she does sex for that period the husband will become sick. My own opinion on the health promotion effect of this is that, during childbirth a mother suffers a pain form bleeding and some mothers can suffer depression and pelvic pain just mention a few, so it will be wise to give her enough time to heal before engaging in sexual activities. (Participant 8)

5.4.5. Subtheme 5: Indigenous health disaster forecasting and rain making ceremonies.

This identified subtheme has revealed not only health practices but established that wellness is derived from the cultural understanding of the role of family, community, and the spiritual world in human welfare. Most of the participants (diviners and herbalists) pointed out that diseases and illnesses are considered by the Kore-kore culture to have physical, mental, social, spiritual, and supernatural causes. Therefore, curation extends beyond physical symptoms to address social and spiritual aspects, too. The study revealed a health disaster prediction and rain making ceremonies as forming part of the major events in sustaining indigenous health promotion for all. Indigenous health forecasting was revealed to be the backbone of their practice as it gives them a plan of action in preparation for the predicted health disaster.

Disaster forecasting and rain making ceremonies forms the integral part of the Pfura indigenous health surveillance, wherein the Gods are consulted and the past, present incidents are used in determining the likeliness of a health community. As a tradition of the Kore-kore people in Pfura,

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rain making remained their culture, however, due to the prolonged drought, it becomes a paramount event, in an effort to promote food security for the indigenous people. The aspect of health disaster prediction/forecasting and rain making was revealed to be led by a *mhondoro (tribal spirit)*, who is a diviner believed to be led by a spirit of a lion. Five participants who were both a diviner and a herbalist shared a similar opinion on these practices as one of them revealed that:

> *Even though nowadays there are now radios and television that are being used to report on the health issues using their scientific apparatus (zvechirungu) us as Shona people of Kore-kore tribe we still believe in conducting sacraments in which we submit our concern be it health, economic or political. In health I can refer you to 1958 when we had an outbreak of chipembwe/whopping cough, here in Manyukisa, the spirit spoke through me and we had a ritual in Zvingwiru sacred pool in Muchura river, yes they were incidence of chipembwe/whooping cough but here there was no fatalities because the ancestral spirit of this land protected us.* (Participant 7)

The importance of the performance of rituals was revealed as crucial to the Pfura people, wherein annually, ceremonies are held in commemoration of the ancestors. The study further noted that these events includes offering of sacrifices to ancestors which in turn demonstrated respect for the ancestral spirits, ensuring protection from the spiritual entities and creating a sense of security.

> *In our culture, rituals have the power to help our patients and families to disengage from the negatives and intentionally focus on the creation of positive emotional states….. 1999 here in Pfura the mhondoro warned us the Korekore about Cyclone (mvura mupengo) that will come ant destroy crops and it will give birth to diseased like cholera and malaria not only to people but to crops and animals………, we consulted and appealed for peace un to our people, year 2000 there was cyclone Elien which hit the southern and eastern side of Zimbabwe. We think our gods for the warning and protection.* (Participant 8).

Two herbalists (participants 11 and 6) who were mentored to practice traditional healing noted the importance of rain making ceremonies as it was the only way they could fight against some deficiency (nutritional) and seasonal diseases,"

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…pleaded with the vaMwari for rainfall for the food security of our people, drought has caused many diseases related to malnutrition like kwashiorkor, scurvy, cholera, goiter, beri-beri and many more. As leaders of these traditional rain making ceremonies we also urge people to plant grass crops like mashava (sorgum) , mhunga(peral millet/pennisetum glaucum) zviyo/rukweza (finger millet/rapoko/eleusine coracanal) they are all drought resistant and nutritious. (Participant 06)

The above sentiment implies that the practices in Pfura, Ward **X** by indigenous health practitioners represent a true traditional health surveillance in which it makes the community to be alert of any health catastrophe approaching and remedy is guaranteed. The participants clearly indicated high level of knowledge on the type of crops to grow in drought prone regions and their effect on the role in promoting health of local people.

5.4.6.: Subtheme 6: Traditional exorcism of evil spirits in promoting wellness

In addition to curative, preventative and promotive practices, the study identified the exorcism practice of driving away evil spirits as one of the central and unique practice in promoting health for the rural folk. The traditional health practitioners of the Kore-kore tribe in Pfura attested to a belief that when they diagnose an evil spirit which causes serious illness and disease, numerous exorcist measures are employed and performed in an attempt to drive away or neutralize the intruder, such as blood-letting, emetics or purgatives and sniffing. One serious disease, which haunts children in the Pfura community is called *buka* (convulsions).

This disease was reported to affect those children who are easily frightened and are very nervous. In Kore-kore, they are referred to as '*vane hana nhete'*, meaning those who are easily frightened. The participants, mainly the diviners, established that this disease is closely connected with witchcraft and many people believe such patients are the victims of witchcraft. It seems as if no permanent curative medicine is known, although *mbanda* a powdered stuff derived from a weed, is burnt in order to drive away the evil spirits whenever the child cries incessantly. During exorcism, although *nyora* (incisions) are both curative and preventive, the diviners argued that they are also symbolically driving out the evil spirits from the patient:

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> *For kids I usually use mbanda weed in which I burnt it for the patient to inhale, but for adults especially vane munyama (bad luck) to disease and prosperity I use the smoke of mafunga-funga weed and sacred animal fats…faced against the formidable smell of the roots, the spirits will submit and exit quickly.* (Participant 2)

Referring to the above statement, serious illness and disease in the rural setting of Pfura is not, as indeed in all societies, limited to children only; it cuts across all age groups in society. The most frequent causal factors reported was witchcraft and curses from angry ancestors. An experienced diviner illustrated that for instance, a person who is thought to have been bewitched is referred to as *aisirwa mamhepo*. The Kore-kore term, '*mamhepo*' is sometimes used synonymously with the word '*munyama*'/bad luck, and both imply misfortune. In these instances, misfortune and illness persistently plague an individual and his health is shattered. Restoration is therefore achieved using the *mafunga-mafunga* roots which are burnt and whose smoke will fill up the house in which the patient sleeps. Thus, exorcism casting away the tormenting spirits.

5.5: Theme 2: Curative health practices

The second identified theme on the traditional health promotion practices in the Pfura RDC, was the curative indigenous health practice being provided by traditional health practitioners/native doctors/*n'anga.* The study discovered that the curative indigenous health practice varied from one traditional practitioner to other depending on their knowledge, skills and the nature of patient's illness. All the twenty-two respondents have revealed that they cure many and different diseases and ailments. The diseases which were mentioned to be afflicting the Pfura Rural, Ward **X** population included both communicable and non-communicable disease. The research participants gave detailed explanation on how they cure and treat different ailments using indigenous knowledge, medicinal plants and animal products.

5.5.1. Subtheme 1: Traditional treatment of diseases and illness

Among the twenty-two interviewees, general ailments like malaria, diarrhea, diabetes, digestion disorders were common conditions that usually face from their day to day consultations. The study revealed different modes of administration in traditional curative practices which include oral ingestion, steaming, sniffing of substances, piercing (African traditional medicine form of acupuncture) and cuts (an African traditional medicine form of injection) known as *nyora*. The

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study established that the traditional health practitioners in Pfura employs parts of the body of an animal or bird, his/her remedies are more often composed of at least one plant, sometimes two or more compounded together, producing a mixture which consumed in a liquid form (*guchu*).

One or more roots are grinded into powder or burnt to charcoal in a piece of a broken clay pot (*chizenga*) and stored in horns or tins, then when required it is then rubbed with the finder into incisions (*nyora*) which are usually cut over the painful part of the body, for instance over rheumatic joints, on the back, over painful chest walls or on site of an aching head.

A herbalist (Participant 7) gave a curative account and he confirmed:

> *During this time of the season (March-April), I receive many adults and kids with malaria as you know that Pfura district is found in the low land of the Dande valley which is prone to malaria. I use many tactics and many types of herbs depends on their availability, the murima tree/purple wood belgia for example is most I use for malaria. I take the leaves and roots then I boil (decoction and infusions/muto) them for 20 minute, allow them to cool and then give the malaria patient. It became so effective if you administer it alongside the mugarahanga/sickle-leaved Albiza fruits especially if the person is having a cough and fever simultaneously. They are ailments that we usually encounter on daily basis like snake bites and tooth aches, still using the same murima tree leaves and barks of it in a powdered form which I rubbed on bite and on the abscessed tooth (mhango yezino). The murima tree roots can be soaked in warm water for some time and I then give them for a dental patient to gargle and the toothache is cured in no time.* (Participant 7)

A female herbalist (participant 14) concurred witho the above sentiment wherein she emphasized the use of ginger/*tsangamidzi* which even people can self-administer particularly to digestive disorders:

> *I have used many herbs for some time to cure digestive disorder (zvirwere zvemudumbu) which includes diarrhea, frequent stomach upsets and constipation, but for now I have adopted the use of tsangamidzi/ginger/zinger officinale which grow here at my back yard. The tsangamidzi rhizomes and roots can be in powdered form or in water. The tsangamidzi cures a range of conditions especially among the aged*

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population. The tsangamidzi powder can used as spice when cooking vegetables for a diabetic patient, I recommend the use of tsangamidzi because it helps in reducing the production of body fats which later causes clots (kudunduvira kweropa). I recommended the use of tsangamidzi to my patient with musculoskeletal problems like joints problem, tendon sprains, rheumatism and osteoarthritis. (Participant 14)

Participant 11, who is both a herbalist and traditional birth attendant, further clarified the administration of tsangamidzi together with munhunguru/governors plum/flacourni indica herb in curing respiratory troubles like asthma and tuberculosis:

The tsangamidzi herb for me is a very effective and easy to administer as it can be administered together with food, you can make it as tea, in porridge, in your veggies and also in water. You see this tsangamidzi herb some time it does grow well, and it dies so, I use the munhunguru instead. The munhunguru tree can be found everywhere in the bush and use especially the source sap from the leaves and the bark powder. For myself I don't use miracle tees from the third heaven, no no no, you see that muwuyu/baobab tree uphill, that is my pharmacy, I use its leaves for diarrhea, inflammation, kidney problems, bladder disease (under active and over active bladder) and cleansing of the blood. (Participant 11)

Two traditional birth attendants revealed that they do not only do midwifery, they also practise herbalism for pre- and post-natal care. However, it was discovered that due to poor accessibility to primary health facilities, most children in Ward **X** suffered a lot from Chipande/nhova/fontanelle. Nhova is an anatomical feature on the skull of every infant which is comprising of soft membranous gaps, so this gap/*nhova* can be a sunken or bulging one which an after-birth cause or genetics. It affects growth, especially the neurological (hwurupi/pfungwa) development.

I use mubvamaropa tree bark which I burnt into powder and then mix with the oil from mufute seeds then it produces a tarry thick mixture which is then apply over the fontanele/chipande. The health of child is my responsibility, you talk of conditions like scabies, rush (mapundu), ring worms (manyongorosi) I use the nhunudurwa/ solanum incanum to bath the body and it works within 24 hours. (Participants 21*)*

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In addition to the above sentiment on traditional curative practices, participants shared their knowledge and great experiences in reproductive and women health with menstrual disorders and urinary problems became central;

> *Menstrual disorder/jeko, uterine problems and genital swelling, the leaves and roots of munzviru/velvet wild medlar/magic tree are boiled and the patient will drink it for a week and for pain blocking during that period I also give the patient the chizhuzhu leaves to chew and swallow the sap(muto) untl he or she is healed. It is generally known as the magical tree (muti wemashiripiti) because of its magical properties. The munzviru tree to me has assisted in curing many disease, since it an indigenous tree it also works as purgative in treating ringworms and the infusion of the roots and bark also cure chest ailments like pneumonia. To diabetic (varwere veshuga) patients, as you know diabetes cause the swelling of limps, so the twigs and roots we pound them and mix with water, so the patient will bath the affected limbs.* (Participants 17)

Despite the curing of many diseases, conditions and ailments, the venereal/*zvirwere zvepabonde*/ sexual transmitted infections (STIs) diseases are also tormenting the Pfura rural district and it has become more common to them (traditional health practitioners) which include herpes, gonorrhea and genital warts. The steep rise in sexually transmitted diseases including the killer disease, *mukondombera*/AIDS was reported to be attributed to promiscuity rampant in today's generation. A diviner respondent blamed western education, with the accompanying absorption of Western values which emphasize individual freedom, as a common factor for these scathing attacks. The study further revealed some major causes of these diseases as migration and juvenile delinquency. In the curation of these diseases and infections many of the respondents concurred on the use of *guchu*/mixture of herbs. Participants 22 articulated that:

> *Youth of today have changed, and they engage in sexual activities at a tender age without the use proper sexual knowledge, almost every week I know out of ten patients, five or six will be having siki/njovhera (gonorrhea, herpes or genital warts) they come to me because they know I don't judge them. These diseases like I said they are aged related most youth are tormented with STIs.* (Participants 22)

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5.5.2: Subtheme 2: Diagnosis of illnesses and problems in the traditional health system

Like the conventional health practice, the traditional health practitioners revealed that diagnosis is key, as it entails a systematic quest for answers to the immediate, efficient, and ultimate cause of a disease. The study revealed that traditional health diagnosis comprises of a combination of family history regarding patient's illness, observation, wherein patient's physical symptoms are noted, patient self-diagnosis whereby the patient reports their problem to the traditional practitioner. Above all, the process of divination in diagnosis included the above but techniques like the casting of divination objects (*kukanda hakata*/throwing bones) and the other aspects like clairvoyance (*kuvuka*) and the interpretation (*kududzira*) of dreams and visions. A male respondent who was a diviner and an herbalist said,"

> *If a patient comes here, the first thing is to ask her/him, what is the problem that have brought you're here? How long have been the problem? Did you get any medication before? as person who have been in the practice I then decide which help I can render. They are conditions like mental illness (chirwere chepfungwa) and cancer (mhuka) we then go to the next level where in I need to see your family members, so that they testify about your illness history. The family members assist me in evaluating life style and relationship do they have which might contribute to the problem.* (Participant 12)

The study revealed that during diagnosis, traditional health practitioners use empathic psychic ability, ability to feel or hear what the patient feels to diagnose the problem (kuhakira). One 76-year-old male diviner (*mushoperi*) observed:

> *I feel as if I was experiencing the same events and feelings that the patient was going through (kuhakira) I will then start to behave like the patient then my interpret will then interpret to the patient.* (Participant 22)

Most diviners mentioned using objects such as shells, money, bones or herbs to guide their diagnosis. For example, many Traditional Medicine Practitioners mentioned they used herbs to show details about the patient's problems. An 86-year-old spirit medium (*svikiro*) with five years of experience, who once treated a patient with depression-like symptoms, observed:

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> *When we want to examine the person, we use some herbs for diagnosis. We blow some herbs onto a patient's face, sitting from a distance. I can tell from the patient's reactions, for example, feeling sulky or moody, that the problem is ancestors have turned against the patient.* (Participant 19)

Two male diviners supported the above, as they further supported and indicated that in contrast to the scientific doctors sensory of perception of the causation of diseases, the traditional practitioners is based on a mystical basis that diseases or illness is due to upset of one's *vadzimu* (ancestral spirit) or to evil practice of a person (*huroyi/witchcraft*). The study established an account on how traditional health practitioner cure and manage patients with mental illness which was reported to be caused by *ngozi* (an avenging spirt), witchcraft or curse from wrong doing:

> *…. throwing bones revealed the cause and if failed will then perform rituals and in many cases a mental illness cure using steaming and sniffing of substances from a wider families of herbs for example for a mentally ill I use the parasite (gomarara remuti) of chirovadundundu herb and the seeds of mufute (castor oil plant) and other medicinal alternatives as effective, I then put the mixture on glowing embers and let the patient breathe. The use of the herbs chirovadundu (that which beats the chest) and mufute (oil) seeds convey the meaning of conquest of the nuisant spirit and perfection of health respectively. Alternatively, chikonye (worm) of a slaughtered ram (uncastrated male sheep) is crushed and rubbed on the affected patient through nyora (incisions). The worm that activates the beast is meant to arouse the victim's consciousness.* (Participants 4)

The majority (n=11) of diviners commented that for cases involving mental illness caused by avenging spirits (*ngozi*) the Kore-kore believe that the only medicine is paying the required reparation hence they have a saying "*mushonga we ngozi kuripa*". It was also noted that in expressing the point that the only medicine for dealing with mental illness caused by avenging spirits the Kore kore people in Pfura do not exclude western and traditional medications. The expression merely emphasizes the primary role of the appeasement ritual around which other medications could be used and that using other medications without the '*kuripa*' (to pay reparation) ritual will not bring a permanent solution to the problem in this instance. Participant 8 who was referred as *mhondoro yeNyombwe* (tribal spirit of Korekore, Pfura) revealed:

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In 1987 there was an avenging sprit which tormented four family members in Chizeza, wherein these family became mentally sick (mipengo) and wild, they came here and sprit in me (sekuru) said the great great father of that family committed murder so for the spirit to be appeased, they have to pay fifteen white cattle to the victims/bereaved family. I led them to Gokwe where the avenging spirit was coming and we paid it off, and the four people were freed. (Participant 8)

5.5.3 Subtheme 3: Referral of patients within the traditional health system.

The study discovered that there is a strong network between the traditional health practitioners (themselves) in Pfura, Ward **X** wherein as well as with the hospitals. Most participants pointed out that the working relationship among them was good as it closed their weaknesses since they don't specialize in same areas. However, within this chain of referral, a person who is much into divination and herbalism is person who receives much of referrals from other practitioners.

Three herbalists shared a same sentiment,

In some case you will find out that some people are not saying the truth about their condition, especially HIV positive patients, they will come and tell you about their problem, me as a herbalists sometimes it is common knowledge to say, why can't you go first and get tested and screened for any diseases by the clinic, so that you can come back and we work with doctor report to manage you condition. (Participants 20).

The practice of referrals among traditional health practitioners as well as referrals to hospitals attested the idea that the traditional practitioners in the Pfura rural district, Ward X acknowledge the essence of medical health practitioners. The participants who were merely herbalists admitted as they commented in the below quotation*:*

All these decisions I reach them after a thorough understanding of the symptoms. if you give an example of a TB patient and diabetic patient, they need to be screened first and vitals like blood pressure, sugar level etc. I can't check for vitals, so it then become very crucial for to refer the patient to the clinic or hospitals. Most of us as herbalist, especially myself I knew and master herbalism through mentorship, they are certain point in time wherein we get challenges in administering a certain herb or

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maybe the herbs I have a proving to be not effective, I then refer my clients to chamangwiza (senior and powerful traditional healer). (Participant 2)

The study further argued that not only herbalists refer patients to either diviners or to clinical doctors, the traditional birth attendants shared their own side of the story which was much of recognizing the existence of conventional/modern health systems as they revealed that nowadays home deliveries are discouraged so whoever consult with them they can assess and refer the person to the clinic:

Experience is the best teacher, having been nyamukuta/midwife for many years, I can easily identify conditions ……………… includes high blood pressure for example. Other factor for referral includes diseases like HIV, asthma, heart disease, therefore I can't assist such a patient, the best way is to refer here to the hospital for good maternity care. A pregnant woman is a person at risk, so usually …….to assist in an emergency only. (Participants 11).

A diviner (participant 16) who mentioned that he had worked for sixty years reported that the networking between them and the hospital was usually in situation of suspected witchcraft and sorcery. He gave an account of individuals who got locked during sex as it was a result of *rukawo* (love chastise/ central lock) a practice which many Kore-kore adopt to avoid promiscuity;

These days you know infidelity is on the rise and women are now using heathen traditional love portions which result in people locking together during sex or they can get a sickness which can't cured by medical doctors. So, I was called from the clinics and hospitals to perform rituals to assist such victims. (Participant 16)

5.7: Theme 4: Herbalism, Christianity and witchcraft

Theme three was identified during an intensive in-depth discussion with a certified herbalist from B and A villages of Ward **X**, Pfura District Council. The discussion revealed and established different views on the relationship and the connection between the use of herbs and Christianity (biblical ideas). Not only did the study reveal the connection, it also identified some gaps and the deep-seated disapproval of the Western gospel of missionaries by traditional health practitioners, who still believe that they have been robbed their cultural independence. This theme became interesting as it emerged during an interview with a male practitioner (participant 2) who identified

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himself as a Christian and he even indicated that he was a deacon at his congregation of Seventh Day Adventist in the village. The Christian herbalist supported his idea (using biblical scriptures) of being a Christian and at the same time utilizes and administer indigenous herbs to cure and promote the health of his community;

> *The majority in todays life they regard herbalism as unbiblical, occultistic and paganistic, and some go further and refer it as work of the vahedheni (the heathen). Let me tell you this…..most of my clients here especially Christians they disguise by summoning a friend/someone to collect herbs with their mind that if people sees me with n'anga () they will call me a heathen. Let me educate them today through you, the use of herbs is not heathen, it is there in bible in Ezekiel 47 verse 12 and Revelation 22 verse 2.* (Participant 2)

Ezekiel chapter 47: verse 12, "And by the river upon the bank thereof, on this side and on that side, shall grow all trees for meat, whose leaf shall not fade, neither shall the fruit thereof be consumed: it shall bring forth new fruit according to his months, because their waters they issued out of the sanctuary: and the fruit thereof shall be for meat, and the leaf thereof for medicine" (Version, 2017).

Revelation chapter 22: verse 2, "In the midst of the street of it, and on either side of the river, was there the tree of life, which bare twelve manner of fruits, and yielded her fruit every month: and the leaves of the tree were for the healing of the nations" (Version, 2017).

The above scriptures clearly supported the participant's view that the herbs and animal products are divine given to the people to promote their wellbeing in terms of curing and protection of diseases and the respondent on the same vein, denounced that herbalism becomes evil if when it is done through ritualism and sacrifices. However, a different view from the diviners was given which then gave a detailed explanation on the relationship between traditional health practitioners (diviners) and god. Two traditional health practitioners who were not Christians described how they connect with god during their healing sessions, they were both diviners using the spirit of mermaid (*shave renjuzu*) and the other with the spirit of the great ancestors (*vadzimu*). The participants concurred on the following:

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God (Mwari) is the great man who rules everything on this land. Yes I we know god is there but when we communicate with him, we do it through vadzimu (great ancestors), we trust and believe that they are in easy access to god who is the creator. (Participant 13)

I don't need to go church to worship god, Christianity came with the white missionaries during the colonial era, so for me I workship my god through my ancestors, who have been with us before vasina mabvi (whiteman/white settlers). (Participant 2)

5.7.1: Subtheme 1: Traditional healing and witchcraft

A diviner (*muvuki*) who was a participant in the study introduced a unique and debatable subject which became a subtheme under the theme on the relationship between Christianity and herbalism/traditional healing. Although most of the participants didn't speak about this sensitive aspect of traditional healing, the only diviner attested that there was a thin difference between traditional healing specifically divination and witchcraft (huroyi). The study understood that the tools that the two use (a witch and a diviner) are the same only for dissimilar purposes. A male diviner with a spirit of a baboon (*shavi rebveni*) reported that even in witchcraft the use of divinatory powers and use of herbs and rituals is central in their effort to cause harm to an individual;

Especially when a person is bewitched by a wizard or witchdoctor, what I do is I do have the power to perform 'back to sender' (kudzosera mhepo) wherein the if it was a disease or chipotswa (physical disorder) it go back and hurt the person who caused it. I can see what a witchcraft does and what they use in their work, I can as well perform it only that myself the intention is to serve a person. Our tools and apparatus are the same but the intended goal is different, witchcraft is a devilish act wherein the purpose is to kill and torment. (Participant 10)

5.7.2 Subtheme 2: The influence of Christianity on the Zimbabwean culture and tradition

A discussion on the relationship and connection between herbalism and Christianity gave birth to a subtheme on the aspect of the influence of Christianity on the Zimbabwean culture wherein the health practices are enshrined. To sum up to the above sentiment a, deeper explanation was

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given by traditional health practitioner who claimed that he was a ten-year-old boy when the missionaries were flocking on the land of Zimbabwe. He narrated that the Western Christianity was not only there to colonize the land but it was there to rob the African knowledge hub for survival that is the indigenous knowledge system. The study revealed that the traditional health practitioners value traditional healing as it was there in their life since time immemorial. Looking very emotional, the participant revealed that it is the right of Africans to claim what is theirs, rather than to call Christianity as their religion:

> *The gospel of Christianity was the opium of the African indigenous knowledge, as it lulled us to sleep and they stole our God given inheritance (nhaka yedu). Christian missionary work was part of the diabolical strategy to colonize and plunder our knowledge and pride. I can safely say it was not about heaven. What heaven?..if the real heaven ever existed the whites would have flocked there and filled it up long before us black Africans even suspected of its existence.* (Participants 4)

In backing the above idea/quotation the study further indicated that in Pfura, there are conflicts between traditional healers and self-proclaimed prophets who have been propagating a campaign against traditional healers in the region, accusing them of practicing witchcraft. The disconnection and mistrust between African-Zimbabwean traditional healing and Christianity was also supported by a female diviner as she put it:

> *That is why we are taking time to explain the nature and content of our African healing and spirituality, to reverse the negative perceptions created by Western Christian preachers literally spreading heresy (falsehoods) about African spirituality, religion and culture.* (Participant 4)

5.8: Theme 5: Challenges facing the traditional health practitioners

As shown earlier in this chapter, the earlier themes revealed overt evidence that traditional health promotion is the back bone of primary health care in the Pfura RDC. However, the study has shown that there are challenges to health promoters (traditional health practitioners) and the practice itself. The response from the study participants proved that although in Pfura, the majority of people utilize their services, as practitioners, they found it difficult to normalize its

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functioning and role in promoting health of the local people. The challenges varied from practitioner to practitioner depending on their areas of specialty.

5.8.1: Subtheme 1: Traditional health practice has low income

Despite the invaluable role of indigenous health practice in sustaining and displaying the African pride of culture and history, the study revealed that the practitioners also do not practise out of passion, but rather to make ends meet. The majority (n=14) of the study respondents pointed out that they are not employed therefore through traditional healing, (it is their job) they expect to earn a living out of it. Although the entire economy of the country is struggling, to the traditional health practitioners, it is worse as their commodities and services do not have standardized pricing, thus the payment is petty and tricky. Traditional healing products were named to be coming from different locations, it therefore made some herbalists charge exorbitant prices because of the scarcity of the product, thus resulted in anomalies in financial benefits and pricing in traditional health products. It was attested that among the traditional health practitioners there was a tug of war in terms of pricing wherein the mentored herbalists were more into financial gain unlike the ones who use the ancestral spirits (*mudzimu*). Reflections included:

> *This work doesn't pay at all, I do it because I don't have any thing that I can do to assist my family. All of my herbs or any healing product they don't have a standardized price (mutengo), we rely on negotiating, look some products I get them as far as Muzarabani, in this industry loss is the song…u see some traditional healers here they just charge anyhow, imagine paying using a chicken/goat (mbudzi nehuku), it doesn't sustain me as an individual.* (Participant 7)

> *"Gven the economic situation I prefer and gift I receive from my patients, so that I can service especially groceries.* (Participant 12)

> *I cannot ask for monetary because the spirit in me doesn't allow that I can get sickness/cursed for pricing my service in monetary form, therefore I only get gift from such as chicken and goats.* (Participant 5)

There were few participants who shared a different view and opinion about financial generation and benefits within traditional healing profession. The study established that the nature of the African knowledge in Kore-kore society is said to be God given, and therefore pricing of services

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is not allowed. The participants particularly the ones who claimed that they use ancestral spirits pointed out that traditional healing to them is not for monetary benefit but the glory of their great ancestors who are there to protect the people of the Kore-kore tribe. It was revealed that if they are charging exorbitant prices, the spirit (*mudzimu*) will curse the person whom it works through (*homwe*). Although many people have received appreciation through large amount of money and gifts, the minority of participants maintained that indigenous healing was not there for sale but to render affordable and culturally appealing health care to the people:

> *To be the spokesperson (homwe) of the departed doesn't give you the permission to amass wealth in the name of traditional healing, you can be cursed to death or chronic illness. We are bound to serve the people of the land; people can only pay in kind (kukandira). Kukandira is sign of thanks giving to the spirit which is not priced but a free will.* (Participant 15)

In summation, these results prove that given the rate at which people are using traditional health as a main source of health, it then calls for the need of setting up its economic value. The practice in Pfura is therefore lacking economic measure to ensure its sustainability and longevity.

5.8.2 Subtheme 2: Poor professional development

The study interviewed twenty-two traditional health practitioners and only ten of them have attended training course in different health aspects like HIV, malaria, cholera and TB. A lack of proper structures to support professional development was a major reason. Participants attested that the Zimbabwe National Association for Traditional Healers (ZINATHA) and the Traditional Medical Practitioners Council (TMPC) only recognize them with certificates but nothing much was done to improve the zeal and capacity of the healers considering the new trends in the health care system. The poor professional development was also condemned as a major cause for amateurism and quackery in the traditional health fraternity, as people are just being registered but without proper knowledge and training in the profession of traditional health. One of the participants, a diviner and herbalists commented that the registration of traditional healers does not clearly test the efficiency of an individual, and he fingered corruption in the issuing of registration certificate of practice;

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This paper (registration certificate) doesn't speak how good my practice is, we need a board of well-experience healers who can monitor our activities from time to time. Some small boys from the villages, because there is poverty they fake (especially the witch hunter-tsikamutandas) and practice, which then put the name of our heritage in disrepute. To be registered you need the testimonial letter from the Kraal head (sadunhu) and your trainer especially a registered practitioner…to me that doesn't justify quality. (Participant 2)

The above quotation does not only speak about lack of training and professionalism; it speaks volumes on the amateurism which is being purported by the witch hunters who are believed to having super powers which are not ordained by the ancestors who own the land of Kore-kore tribe. The *tsikamutanda*s are believed to be having super powers that only last for a short period because it is riddled with quackery and fraud, which is against the *mhondoro* (tribal spirits). The study established that most of the practitioners around the community they practice, but without much experience and knowledge on how to handle this practice;

Let us be given proper skills, myself I would want to know how to measure BP for example because as herbalists sometimes I meet people that you need to know their status first before you give them anything. (Participant 11)

This shows that the traditional health practitioners lack the necessary skills that are needed in assisting them in their practice. Given the lack of modern clinics which are scattered across the district, it is a must that, these traditional practitioners be trained to be able to assist in vital signs checking before they administer their herbs and all other traditional health processes.

5.8.3. Subtheme 3: Age of practitioners and future of traditional health practice

In an African tradition, a traditional health practitioner is expected to perform sacrifices annually through rituals (*kuridzira*) when the spirit is being rejuvenated its vision, therefore it needs the individual to be not only spiritually fit but physical fitness is a perquisite too.

I do have family members but none of them is willing to assist given my advanced age, if I am dying I will be dying with my powers because none is willing to inherit.(Participant 03).

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As revealed on the demographic information of the study participants, most of them are over 75 years of age. This advanced age has affected their day in day out performance as many of them are experiencing mobility problems. It is now becoming a cumbersome duty for the practitioners to be able to mentor the upcoming traditional healers as they seem to lack the power and energy to develop new comers in the profession. It is therefore difficult for them to go to the forest to harvest different herbs or even to attend health training which normally are held in distant clinics. The ageing traditional practitioners also gave an account on how the indigenous knowledge system particularly on health was affected as it was mostly relying on them as old custodians of indigenous knowledge;

> *Nyoka huru aizvireme (an African proverb which explains that a traditional healer cant heal him/herself), I am partially blind, my lower limps gives me problems for me to walk, therefore you see the number of consultations has fallen in recent years…..I used to have patients some whom could stay here for months.* (Participant 9)

5.9 Theme 6: Challenges facing the traditional health practice in Pfura RDC

The study showed that apart from practitioners being affected, the challenges further made a blow on the "practice" itself. Below are the subthemes identified as challenges to traditional health "practice".

5.9.1. Subtheme 1: Lack of proper consultation facilities

The traditional health practitioners in Pfura groaned about lack of proper and user friendly consultation rooms that would accommodate their patients. It was revealed that the traditional health practitioners particularly the herbalists have turned themselves into vendors and hawkers which is a state of embarrassment to the traditional health label. The traditional health practitioners wish if they could be treated the same way medical doctors are, given a proper complex wherein they will be divided into their specialty. Apart from all these problems, the diviners and traditional birth attendants have resorted to be using their homes as consultation rooms, which they condemned as inconvenience. A male diviner attested that not only is consultation rooms is good for patients but user-friendly venues will reveal how an African *nhango* (a consultation room of n'anga) hut looks like and its representation of Kore-kore culture;

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Look around the room, you can see that this room is also the storeroom, it is spare room in which if my clients are coming I think they don't feel comfortable, it will be wise if we I can get a proper stand and built a nice hut which is user friendly and welcoming. (Participant 1)

They are some instances wherein we need to perform rituals, at my house it's not proper, but if the village can give us some land and we create our huts it will be better. (Participant 10)

5.9.2: Subtheme 2: Nonexistence of research and scientific assistance in traditional health practices

A lack of proper research and scientific approval was one of the challenges which was discovered to be a constraint to the traditional health practice in Pfura. Although very few (n=6) respondents (diviners) did not like the scientific intervention as they refer it to be of more Eurocentric which does not sit well with them. However, the majority (n=16) pointed out the lack of research and scientific assistance as some of the major factors that are costing the practice for success. It was established that the practitioners are aware of new diseases and the drug resistant of some illness, which have given them a setback. One of the participants said that research and scientific assistance would assist them in experimenting with some of the herbs that they think are available to cope up with new illnesses like cancer, but it is difficult as some herbs they feel they need a clinical trial. The traditional health practitioners in Pfura, acknowledge the importance of modern scientific research in assertion and trail of herbs as it will reduce the danger in the profession. Moreover, due to some media houses despising their practice, they want scientific research to be done for them to prove their point. A herbalist (participant 17) attested:

Our knowledge is from the ancestral spirit (vadzimu) and for other it was through a mentorship process by their father, I do acknowledge that in as much I can't see with my naked eyes things like blood flow or how does the body react to certain dosage, I would be happy to have researchers who can work with me. I can identify thousands of herbs …… through dreaming. Research (tsvagurudzo) will assist not only me but to some upcoming practitioners to understand more on the identification of herbs and animal's products for health promotion. (Participant 17)

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This statement shows that even though there is lack of research and scientific assistance as well as training activities, traditional health practice has not received due support and attention. Member participants share a wider vision on the support of industrial development through research that it should focus on activities ranging from the propagation of medicinal plants, proper processing technologies to improve quality and yield, new formulations to new products and the marketing of finished products;

> *The Chinese had produced a lot of herbs that I sometimes are do use, well refined herbs, I think it's because they work well with Universities where they meet professors with skills needed to identify refine herbs with standard, which make it well known throughout the world*. (Participant 14)

The study indicated that the main problem facing the use of traditional medicines is the proof requirement that the active components contained in medicinal plants are useful, safe and effective thus research.

5.9.3. Sub theme 3: Extinction of herbal plants and medicinal animal products in Pfura

The traditional health practice in the Pfura RDC has presented a pivotal role for the primary health care of the people and currently the demand is rising than expected. The rising demand was credited to the fading economy of the country. Therefore, their practice highly depends on the harvesting of biodiversity, and the other primary ingredients used are from animals, plant species and mineral resources. The participants, especially the ones who practice herbalism, attested that many plants were facing extinction. It was revealed that not only the herbal plants, but also the animal products were becoming scarce because of human settlement and people doing unauthorized hunting of endangered species which are rich in traditional medicine properties. Extinction was pointed out as one of the major challenges to the traditional health promotion practice as it is leaving them with limited option for the cure and prevention of diseases:

> *We cure and prevent a variety of diseases which does not needs the same plant or the local plants. Local plants I mean the shrubs and plants that we can find backyard or just in a bush, they are certain herbs that are found in specific locations, which because of human activities like settlement and agriculture these plants were destroyed…Due to destruction of habitats the unique animal populations*

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(pangolin/haka, gora/vulture) of specific medicinal values has decimated which then gives a challenge to the traditional health practitioners who sometimes use animal products" (all herbalsits and diviners concurred). (Partipant 09)

The traditional practitioner who claimed that she was also part of traditional leaders in Pfura attested that harvesting of spontaneous flora including those in forests which resulted in many plant species have extinct and some are endangered. Industrialization like mining has also destroyed some of their sacred places which were normally used to contact some ritual for the promotion of the Kore-kore culture wherein the powers of the traditional healers were reinforced.

Like I indicated before that we have these boys, tsikamutands/witch hunters and some bogus healers, they just harvest herbs in a destructive manner, when you take a herb you cover with soil for it to grow but this guy's thy destroy, and also development of house and roads has destroyed some our sacred forests. (Participant 3)

5.9.4 Subtheme 4: Poor and false documentation of the traditional health practice

The study participants have revealed that their practice lacks proper documentation as it was only relying on oral tradition. Oral tradition was despised by colonialists as it was seen as misrepresenting facts about traditional health practices, record keeping therefore remained a challenge to the practice as the information were claimed to be diluted through word of mouth. Proper record keeping was revealed to be forming any integral part of proper practice since they rely on the knowledge handed down to them from their forefathers. Two diviners attested more to poor documentation giving reasons that the Kore-kore ancestral spirits also contribute to poor documentation does not support them too.

I didn't go to school and I cannot read and write, how can I keep the history and old too look at me!. (Participant 16)

For me it is a taboo for to use phone or even theses advance technology, I can be cursed , recently I requested my ancestor to for me to be a able to have a small cellphone for calls only…that's why cellphone or any device is prohibited in my consultation palace/nhango. (Participant 20)

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Poor documentation together with false reporting by media houses of charlatans who published traditional practice is heathen and evil. Only if the documentation of the practice is given attention, it will be a success to them as some falsehood presentation has made traditional practitioners to clash with the Christianity world of prophets.

5.10: Theme 6: Strategies to guide good traditional health promotion in a rural setting

The present study on the role of traditional health practitioners in promoting health in the Pfura RDC maintained that nearly three quarters of the modern medicines are derived from traditional and natural products, many of which were first used in an indigenous medicine context. Traditional health practice in the Pfura RDC was praised to be a resource for primary health care, innovation and discovery, therefore it needs sustainable strategies to safe guard it for posterity. Several strategies were given by the participants who indicated that for a good traditional health promotion in a rural setting priority is codification and legislation was a prerequisite. The codification was recommended the framework for internationalization, the preservation of the traditional health as well as integration.

5.10.1 Subtheme 1: A review on the codification of the policy which govern traditional health practice

The participants attested that despite the existence of Traditional Medical Practitioners Council together with ZINATHA for the past years, the welfare of traditional health practitioners is in shambles. Given an apparent recognition of the practice, appropriate legislation to facilitate the functioning of the Traditional Medicine Board is usually inadequate or totally lacking. Most of the study respondents gave different grievances on the status quo, but however their opinion concurred on the issue of codifying and reviewing the policy of recognition, and the regulation and registration of traditional health practitioners.

Given that most of the Pfura population relies on traditional health, the practitioners stated that the national policy doesn't protect neither the practitioner nor the knowledge, moreover the government has not yet promulgated edicts or decrees regarding regulation and recognition of the practice. There were suggestions that the traditional healers should be directly funded from the government as they were serving the same purpose as the conventional health systems. The mobile herbalists emphasized the idea that there should be no restriction in terms of moving

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around selling herbs and the illegal herbalist were supposed to be punished by the law. One of the participants suggested that there should a proper policy that governs the selling of herbal products and this policy will therefore safeguard the financial benefits of the traditional health practice;

> *Unemployed youths ……doing magic in name of traditional healing form example the tsikamutandas (witch hunters), we then expect the hand of law to deal with that to serve our practice, but that is not done because the laws are not clear. The accreditation of traditional healers is not straight, therefore we need specific policies. We need to be invited in the crafting of policies…..i need a policy which does away with the importation of Chinese herbs which are now destroying our market. ”* (Participant 6)

The other diviner added

> *We cannot cry of extinction if we were having laws that governs the extraction and harvesting of species and mineral resource for traditional medicine and these policies we want them to be suggested by us, in a bottom top approach but not the other way”.* (Participant 4)

5.10.2 Subtheme 2: Internationalization and commercialization of traditional health practice.

It was evidenced that the traditional health practitioners in Pfura wished the Zimbabwe traditional medicine was handled as in other countries, such as China and India. Worldwide, the Chinese traditional medicine, and the Indian Ayurveda, is flooding the markets of traditional medicine. They suggested that for a proper health promotion, the Zimbabwean traditional medicine needs to be internationalized, that can be supported through a standardized packaging of herbs for international customers. The internationalization was given as a breakthrough as it promotes a large inter-African trade in medicinal plants which in turn will benefit the economy as well as recognition of the Zimbabwean traditional health practice. Internalization of the traditional medicine aspect was clarified to be a solution to problems relating to low income and insufficient recognition of the practice. A herbalist (participant 18) indicated that he had turned himself into a hawker reported;

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Our African medicine is losing market from one day to another, every corner, especially in town you will find a Chinese medicine shop if not an Ayurveda one, I think they win customers because their packaging is good and attractive, we wish to do the same. Yes, some can shun it by I think our practice needs to be civilized so pick up with speed of change and still maintain our tradition. (Participant 18)

5.10.3. Subtheme 3: Traditional health conservation sanctuary and traditional health training schools.

The study indicated that a good health practice in a rural area was possible only if the African tradition is revived and protected against extinction and destitution. A female participant who was a Traditional Birth Attendant (*nyamukuta*) indicated that the traditional health practice was losing ground due to the eroding African culture which upholds the traditional health system. She gave an example of taboos which are walloped by civilization and the dying power of some spirits due to neglecting traditional ceremonies. The herbalist particularly suggested that counter to extinction and over harvesting of the biodiversity, there must be given land to erect sanctuaries that will preserve the herbs, animals and plants for medicinal purposes. It will be therefore necessary that systematic cultivation of medicinal plants will be introduced to protect threatened species. In terms of promoting the upcoming practitioners and quality practice in field of health promotion. The study recommended the development of traditional health schools wherein interested individuals, particularly the Kore-kore people can be mentored on the identification of herbs and diagnosis and administration of herbs thereof. A herbalist claimed that he was an accountant of the 1960s stated:

Habitat destruction due to settlement and other natural and man-made destructive influences unless we take energetic conservation measures are taken to ensure their continued availability through the establishment of medicinal plant gardens and farms…we want even our kids to study traditional medicine at college/university level, if you go to China or India they have such programs it them makes it recognized unlike here it's about its history through anthropology at University of Zimbabwe but not its practice. (Participant 2)

The creation of indigenous health schools will assure and preserve not only the indigenous health practices and herbs, but it will assist in the documentation of the indigenous health practices for

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the benefit of the future generation of particularly the Pfura people and African at large. The study further established that the preservation of indigenous knowledge through these schools can be more accurate if it emerged and attached to a university structure wherein students can enroll for degrees and certificate in indigenous health practices.

5.10.4: Subtheme 4: Multi sectorial approach to traditional health promotion

As the participants identified misrepresentation of traditional health practice, an opinion for a multi sectoral approach was suggested by the majority (n=08) of herbalists and traditional birth attendants. It was evidence that there is a confusion among the traditional health practitioners in the Pfura Rural District Council, as they fail to clearly understand which governmental ministry or institution represents them. As they are registered with Traditional Medical Practitioners Council and being represented by ZINATHA, it was then not enough as most of their grievances were not attendant to and they suggested that some other governmental organs like the Judiciary, Environmental and Arts and Culture be included in spear-heading their concern. The participants condemned the government of Zimbabwe for not giving them a specific department that deals with their problems and interests. Four herbalists concurred on the following respond from participant 07:

> *We are only being registered to be monitored by ministry of health through TMPC &ZINATHA, we don't have the support of other ministries and governmental institutions for example ministry of legal affairs can assist us in the lobbying of regulations and protective measure in the practice. All these issues of extinction, quackery and poor income it can solved if stakeholders like finance, environmental management agency(EMA) and judiciary respectively.* (Participants 7)

5.10.5 Sub theme 5: Integrating the traditional medicine and modern health promotion practices

Although in the Pfura RDC, the majority of people rely on traditional medicine, the study participants attested that the clinics and hospitals are available and they even refer some of their patients. Therefore, it can them be argued that in Pfura there are two health systems which are the traditional and allopathy which are seemingly working for the same goal but in parallel ways. The study has established that the two systems therefore need not to clash but rather to integrate

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for a common goal (health promotion for all). It was revealed that within the context of traditional health promotion, the two can blend together in a beneficial harmony, using the best features of each system and compensate for certain weaknesses in each. Given the current situation of the working relation between the two systems in Pfura, participants admitted that they are registered as traditional health practitioners, as sometimes they can receive patients from hospitals, but the relationship is incomplete because it is not formal, and that compromises the payment.

> *I receive patients especially the ones suffering from cancer, they say I was referred by someone from the clinic, look when they go to the clinic these people they pay and it is formal, but now they are here they just come and negotiate and some even pay in kind….the government through ZINATHA we supposed to be admitted to work as traditional healer under the same pay roll with nurse. What about that*? (Participant 12)

> *As a mere herbalists it is very difficult for me to see or determine the state of blood circulation, heartbeat, temperature etc. but if we can be recognized to be having a proper referral from the hospital not this referral that we have….the nurses out of mercy will just refer patient on personal understanding not a professional referral.* (Participant 14)

This sentiment clearly suggests a complete merging of both systems whereby the traditional healers are included in the hospital health care, specifically assisting in diagnosing different diseases which are thought of being culturally based for example *zvipotswa* (physical disorder characterized by swelling and pain on the body joints). *Zvipotswa* ailments are believed by the traditional practitioners to be caused by witchcraft and sorcery. Thus, total integration will have the doctor assist with a scientific explanation of how the disease has taken root in the biological system, at the same time traditional system, particularly the diviners on the other hand, informing an explanation involving aspects of witchcraft, annoyance of the ancestors (*kutsamwa kwevadzimu*) or any other mystical reasons. The study discovered that the mutual referral was there for some time but the referral was not beneficial as it was just done informally; the traditional practitioners want it formally rather than to be considered as the last option. A diviner further supported:

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I think it will very interesting that even our ancestors will also be happy to see us having our own wards (in hospital) in the current health system, that will be a good recognition. So far we have proven that we can do that, looking at several diseases that we cure and manage every day. (Participant 8)

5.10.6 Subtheme 6: Integrating traditional health system with medical research institutions.

During the interviews three of the diviners and two herbalists maintained that the integration should not be as the one of merging the two systems per ser. The study understood that traditional healers in the Pfura rural district want traditional health practice to be independent from the conventional health system. If the Zimbabwe Medical Research Council collaborate with the traditional health practitioners, they can provide a platform for scientific experts to approve and regulate herbs and any medicinal products they produce for safety use. The study attested that the traditional medicine in Pfura only needs scientific integration than to be merged with the modern health system as they feel undermined and want to be independent and run parallel to the modern health system:

Before colonization there was no hospitals, we were the hospitals, so why do you want to attach us to them they better attach themselves to use. Yes, I know we don't have machines to approve some herbs. Let research work with us. We feel that the nurses and medical Drs don't understand how important we are, may because they went to school. Let the research come and monitor our practices, they are the only people who can validity our work than anyone else. (Participant 11)

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CHAPTER 6

DISCUSSION OF THE STUDY FINDINGS

6.1. Introduction

This chapter discusses the findings of the study. It also highlights key findings that provide foundational insights for future studies and comparison with findings from other studies. The discussions were done following the key themes and subthemes identified in the study. The aim of the study was to explore the role of traditional health practitioners in promoting health in the Pfura Rural District. The study established that traditional health practitioners in Pfura play a crucial role in providing primary health care to the given rural setting, with a multiple array of traditional health practices. The traditional health practices among others included preventative, curative and promotive measures which are being done by well experienced diviners, herbalists and traditional birth attendants. The study further established the differences and similarities between the African traditional healing practices and Christianity.

Even though traditional health promotion in the Pfura Rural District is central in providing health care for the locals, the study indicated that there are also major challenges which the practice and practitioners are facing. These challenges revealed in the present study included poor professional development of the practitioners which was exacerbated by the nonexistence of research and scientific assistance. The demography of practitioners also was noted as a setback in the practice as it contributed negatively to the sustainability of the traditional health practice. The natural extinction of natural herbs has been identified as a blow to the practice. Poor policy formulation has made traditional health practice in Pfura a laughing stock, yielding a poor economic value and poor and false documentation of the practice. Given the challenges, the study further recommended strategies that can enhance a smooth traditional health practice in a rural setting, which will be discussed under recommendations section.

6.2. The profile of traditional health practitioners

The study findings prove and categorized different types of traditional health practitioners that are found in Pfura, who are now offering primary health care to the rural folks. These practitioners include diviners, herbalists and traditional birth attendants. Most of these practitioners can offer one or two services − either healing through herbalism or divination, with a few individuals that

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also act as overseers and custodians of the Kore-kore culture, as they provide a medium of communication between the people and the departed ancestors.

A study by Zuma et al. (2016) provided a similar view wherein they suggested that traditional health practitioners in a rural setting of Kwazulu Natal, South Africa, occupies multiple categories of healing, that is, they practice across different healing types with services that go beyond the uses of herbs for physical illnesses or divination which include, but are not limited to, custodians of the traditional African religion and customs, educators about culture, counsellors, mediators and social protectors. Zuma et al. (2016) developed a claim that, "all the healers put emphasis on their relationship and connection to the ancestral and spiritual worlds, and said that who they were and how they executed healing was from the guidance of the ancestors", this claim was opposed in this study.

The findings of this current study indicated that not all practitioners practice through a spiritual and ancestral world, and this was demonstrated by the responses of herbalists who were mere practitioners of natural herbs which they administered and prepared without any spiritual or supernatural assistance. Therefore, these contrasting views suggest that traditional health practices are not limited to spiritual or ancestral instruction, but they are also generated from mere indigenous knowledge of the local people as it is handed down to posterity through oral tradition. The study profiled the traditional health practitioners in Pfura, and it established two avenues to becoming a traditional health practitioner; those of a spiritual calling, and mentorship or informal learning from close family members. In his study in Ghana, Tsey (1997), argues along similar lines that there are three classes of becoming a traditional health practitioner − informal learning (mentorship), formal internship (apprentice) and spiritual calling. Chavhunduka (1999) mentions the classes in the Zimbabwean context which further validate the present study's view on avenues of becoming a traditional health practitioner.

The avenue of spiritual calling was given much attention by Zuma et al., (2016), wherein it was posited that for one to become a traditional healer in South African traditional cultures, was not self-decided but instead was determined by spiritual entities or ancestors and required demanding and difficult training which participants had no choice but to comply, with some experiencing illness as a result of the calling. The current study demonstrated the same sentiment where diviners have disappeared for months citing reasons that they were abducted by the spirits of the mermaid (*shave renjuzu*) to which they received trainings in the underwater world for months. A

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study in South Africa too, provided confirmatory evidence that the grueling process of becoming a healer is undesirable to families, mainly because people did not understand it (Reeder, 2012). In this view it can be drawn that traditional healing is more of a spiritual and cultural aspect, which in turn, calls for people who practice it to respect the ancestors of a certain land or community.

The current study appears to confirm the view of many studies across the world that assert that 80% of the global population rely on traditional health for their primary health care (Qi & Kelley, 2014). The validation was shown with a present higher frequency of patients visiting/consulting with the traditional health practitioners in the Pfura rural district, ward **X,** wherein it shows that most of the traditional health practitioners in the study are receiving more than sixteen patients per week. Kpobi, Swartz and Omenyo (2018) buttress the present finding by showing that high utilization of traditional health is probably as a result of African socio-economic status, shared beliefs about illness and wellness thus determine the pro-African help-seeking behaviors of many people in Africa. All these given assertions from different studies done in Africa give much weight and support to the present study's findings which revealed a high utilization of indigenous health in the Pfura rural District of Zimbabwe.

In contrast to the western medicine, which is technically and analytically based, the above discussion shows that traditional African medicine is popular because it takes a holistic approach. That is, good health, disease, success or misfortune are not seen as chance occurrences but are believed to arise from the actions of individuals and ancestral spirits according to the balance or imbalance between the individual and the social environment. The practitioners of traditional medicine therefore specialize in particular areas of their profession, in the same way as orthodox medical practitioners. Thus, we find some traditional medical practitioners who are experts in the use of herbs (herbalist), others who are proficient in spiritual healing, especially the use of incantations, while still others combine both. There are also traditional bonesetters and birth attendants, although in Zimbabwe, birth attendants are banned. In many African societies, one type of healer provides several or all therapeutic services, whereas other have separate practitioners for different functions.

6.3. Promotive and preventative practices of traditional health practitioners in Pfura

The study demonstrated an ethnomedical approach to wellness as it suggested that it is derived from the cultural understanding of the role of family, community, and the spiritual world in human

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welfare. Most participants (diviners and herbalists) pointed out that diseases and illnesses are considered by the Kore-kore culture to have physical, mental, social, spiritual, and supernatural causes. Therefore, prevention and curation extend beyond physical symptoms to address social and spiritual aspects, too. In the same vein, Igwesi-Chidobe et al., (2017) propounds that the quest for health shades into issues of cultural beliefs with a basic explanation that in illness there is an underpinning of the supernatural, the most often evoked agency is ancestral spirit anger. This is a belief which is very common in rural settings in Africa, which the Pfura RDC forms part of. In explaining the high usage of African medicine, many studies postulate that African people believe that upsetting the ancestors produces a disturbance and hence disharmony and illness occur, therefore there is need for spiritual cleansing and ceremonies.

Given the above view, this study therefore noted and established that preventative traditional health practice is central and crucial for African people to ward off negative spirits like a mischievous or evil spiritual being that is responsible for many of life's misadventures and accidents. Given that curses from living people, and the ill will anger ancestral spirits is the prevailing potential problem for Africans, therefore these negativities must be prevented whenever possible through herbal potions, creams, and ritualistic actions such as sacrificial offerings to the ancestors. This version of preventive medicine differs markedly from that of the west. It therefore defines the ethnomedical approach to health promotion as stipulated in the conceptual framework of this study.

In the Pfura rural district, the traditional healers reiterated that they practice ritual ceremonies from time to time, not only for cultural purposes, but to conduct spiritual, prediction on issues that can affect the wellness of the people. These forecasts included drought, cyclone and other natural disaster and outbreaks of disease. This makes them central in promoting health of the people given their role in alarming for disaster preparedness of the rural community. Few studies have so far covered this aspect of traditional health surveillance, which is central to the Pfura diviners. Since modern public health officials rely on health providers, laboratories, and other public health personnel to report the occurrence of notifiable diseases to state and local health departments. These findings give a fertile ground for a more multi-disciplinary study which will be able to further explore the essence of traditional early warning systems in different areas that affect the health of communities.

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The use of traditional health information, scientific data, monitoring trends or evaluating the effectiveness of intervention activities would be beneficial if the traditional health system is included. In favor of the same sentiment, Ishak and Nassuruddin, (2014) emphasize the role of ancestral spirits in the healing process and general welfare of a given community wherein the traditional healer is to call, involve and persuade the ancestral spirits to come down, bless and take part in the chosen traditional healing, and to ascertain that the healer and patient performers are well protected. Furthermore, in Malaysian culture, a small altar, is carefully and ritualistically prepared to worship, and pay homage to these ancestral spirits and to the gods to help heal the patient, during these worships, certain future hazards are foretold.

6.4. Traditional health taboos and norms as a practice of promoting health

According to this present study, traditional taboos and norms form the concrete part of preventative and promotive traditional health practice. The current study singles out that health taboos have been central to the sustainability of traditional health practice in Pfura rural villages from time immemorial. However, with time, the study blamed Christianity and civilization attesting that the taboos to some extent have lost value over the protection of indigenous health promotion. However, there seems to be no compelling reasons to argue that taboos may no longer be limited to the realm of magic, superstition, and irrationality in anthropological discourse (Zuesse 1974), but their more pragmatic functions are still not understood. Some schools of thought attest that although the content and coverage of taboos are dynamic over time, strong adherence rates can be shown to be very high in regions like Madagascar and West Africa, demonstrating their deep social value (Seaman et al., 2018).

The identified traditional health taboos in the Pfura community revealed a strong idea and effect in preventing illnesses and disease as well as in protecting and promoting the wellbeing of the indigenous people, were grouped into sexual, environment and food taboos which govern their society. Further evidence supporting these findings were found in the work of Risiro, Tshuma and Basikiti (2013) who did a study in the Zaka district, which revealed that some plant species are planted around homes with the belief that they ward off lightning and evil spirits. However, in the medicinal sense they identified that these plant species were herbs which were used for certain diseases. This study from the Zaka district indicated a strong idea behind environmental taboos; it then answered the question of WHY? Which the present study did not answer very well.

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Various taboos are reported to be taken care of before extracting medicinal herbs, for example, exposed plant roots are covered with soil with a belief that the ill person is not going to get cured if the plant dies. This belief ensures that traditional healers would not destroy the whole plant when extracting medicine from plants. Along similar lines, Nyota and Mapara (2010) posit that the traditional healer collects part of the plant to avoid extinction and destruction of plants for sustainability and conservation for posterity. On the basis of the evidence available, it seems the present study only covered that taboos are for traditional herb conversation and norms which protect behaviour, Golden and Comaroff (2015), bring in a new idea on the subject of taboos in health, they gave an unfathomable understanding which says that rationales for species specific avoidance vary widely, across the world, the species might bring toxicity, might be a sacred symbol, might be an embodiment of human ancestry, or might have an unfavourable behaviour or physical appearance. For example, in Madagascar, it is a taboo to have sex in the bush because it is said to offend the near-by gods and the earth goddess who may strike the offenders with venereal and other diseases.

Several scientific explanations can be given for this taboo (Golden & Comaroff, 2015). In health for instance, it helps to ensure that sex does not take place in an unsafe environment such as the bush where there are dangerous insects, scorpions, and snakes, not to mention micro-organisms. There's also the possibility of a heart attack or bleeding on the part of any of the parties, which could prove fatal, especially, if the farm or bush is far from home. It is also to deter the incidents of rape, which often occurs in the bush, and related health-risks. However, due to technological development in which some of the explanation of taboos are published, it is now a challenge for these taboos to continue to carry their hidden meaning. Taboos are exposed as some people are converting to Christianity and they shun traditional health practices as heathen.

Therefore, the aspect of taboos in the traditional health system cannot be downplayed is it has a hidden force behind not only the sustainability of the practice but also the safety and efficacy of the system itself. Given the above sentiments and assertions from different studies, the present study recommends that further studies be done to uncover the reasons behind many taboos for the society to understand, even though cultural values do not allow the interpretation of most taboos.

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6.5. Curative traditional health practices

Not only are conventional practitioners performing diagnoses; the current study revealed that before the healing begins, diagnosis is key, as it entails a systematic quest for answers to the immediate, efficient, and ultimate cause of a disease. Traditional health diagnosis comprises of a combination of family history regarding the patient's illness, observation, wherein the patient's physical symptoms are noted, and patient self-diagnosis whereby the patient reports their problem to the traditional practitioner. These yielded findings of the present study are consistent with the study conducted in South Africa amongst the Bapedi healers, by Semenya and Potgieter (2013), who demonstrate that diagnoses of STIs by traditional healers is primarily based on the symptomatic presentation and certain behavioural traits before commencement of the treatment. Sememnya and Potgieter (2013) indicate that these Bapedi healers also closely observe the condition of their patient and request information about prevailing symptoms.

Despite the similarities of diagnosis in traditional health practices across Southern African cultures including Vhavenda, as confirmed by Mulaudzi, Chinouya and Ngunyulu (2015), my study tends to shed more light on the spiritual diagnosis by diviners. In diagnosing diseases which are spiritually caused, the diviners (excluding herbalists and traditional birth attendants), techniques like the casting of divination objects (*kukanda hakata*/throwing bones) and other aspects like clairvoyance (*kuvuka*) and the interpretation (*kududzira*) of dreams, are central. This aspect of spiritual diagnosis following the given techniques can be credited to the concept of an ethnomedical approach which asserts that a disease in the African culture or context is not only by physical symptoms but spiritual therefore consulting the ancestral spirits is crucial.

The present study is not alone on the view of spiritual diagnosis (use of objects and herbs) given, an account from a study conducted in Tanzania among the traditional healers residing in the Kilombero and Ulanga districts, who revealed that if no specific signs are seen, healers will perform rituals with a chicken (patients will bring a chicken for the consultation of the oracle) (Kante et al., 2015). The chicken is killed and then carefully examined during an autopsy for any abnormal and pathological features which relate to the problem of the patient. Indeed, as noted by Neba (2011), traditional methods of diagnosing diseases are very complex and complicated. Given the variety of diagnosis processes which vary from culture to culture depending on the individuals calling, Hewson (2012) also emphasizes that a common diagnostic practice amongst southern African traditional healers is to throw the bones which are usually made up of small

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animal vertebrae, as well as shells, stones, or cultural objects such as dice, coins, bullets, and beads. The interpretation of bones in Africa was reported to be universal by many studies, such as the one by Mufamadi and Sodi (2010), who argue that traditional healers read the 'bones' for their significance in terms of how they fall in relation to each other.

Depending on their knowledge and the nature of patient's illness, the present study indicated that the curative health practice is done by traditional health practitioners and it includes treatment of different ailments using indigenous knowledge, medicinal plants and animal products. The curable diseases were reported to range from mild, acute to chronic conditions which include malaria, diarrhea, diabetes, digestion disorders, dental care, STIs, musculoskeletal problems, and menstrual disorders. A number of pant species have been presented in this study which are being used as medicine. A variety of plant species are used in the controlling and curing of these given diseases.

An example was given for post-natal care wherein traditional birth attendants demonstrated that there is a condition called fontanelle which haunts newly born babies. The fontanelle can be a sunken or bulging one, caused by genetics or an after-birth condition, and it affects growth, especially neurological development. The study acknowledges the use of *mubvamaropa* tree bark which is burnt into powder and then mixed with the oil from *mufute* seeds. This produces a tarry thick mixture which is then applied over the fontanele/chipande and conditions like scabies, rush (*mapundu*), ring worms (*manyongoros*i). The *nhunudurwa*/ solanum incanum is used to bath the body and it works within 24 hours. The cure of fontanelle by traditional health practitioners in the Zimbabwean context has been applauded and it therefore brings in the idea and confirms the assertion that in the history of health promotion in indigenous communities of the world, there are specific diseases that had been cured better with traditional means.

The Pfura traditional healing which includes the burning of medicinal weed in order to drive away the evil spirits whenever the child cries incessantly as well as exorcism, *nyora* (incisions) are both curative and preventive, the diviners argued that they are also symbolically driving out the evil spirits from the patient. Lin et al (2009), and Hijikata et al. (2006), attest that the practices are similar and are of cultural importance to the Chinese traditional healing. The available evidence from this study seems to suggest that the herbal plants are central to the traditional health practices, particularly in Zimbabwe and Africa in general, however the use of these herbs varies from culture to culture depending on the knowledge and skills of the practitioner as well as the

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patient's illness. For instance, in South Africa, most plants are used to enhance fertility as fertility is a dominant theme in the culture of black South Africans as it ensures preservation and propagation of the tribe (James et al., 2018). Herbs like the *tsangamidzi*/ginger was reported to be effective in curing musculoskeletal problems (such as tendon sprains) and digestive disorders. A study in Mali, and Ethiopia shared the same view that *Zingiber officinale* (Ginger) was reported to be frequently used to treat urinary tract infections and pedal oedema, the most common indications for herbal medicine use reported by the study population.

The above corresponding ideas from studies conducted in Africa reflect a high level of heterogeneity of results in the use of herbs in promoting health. However, a comparison was done with developed countries studies and the use and utilization patterns differed little between Australia, Europe and North America (Street, 2016). It can be concluded that it might be an indication of the importance of localized traditions and customs which drive herbal medicine use, even where similar herbal medicines exist. Therefore, further work examining facilitators and drivers of herbal medicine use may help to contextualize and extrapolate the associations uncovered in our study.

All of these converging facts supporting the present study justify more and attest to the report of World Health Organization (Oyebode et al., 2016) which states that traditional health practices are still very common in many African cultures with an estimate of 70 to 80% of the people in developing countries using traditional medicine as a major source of health care. The higher number of traditional health consultation in the Pfura rural District is similar to a previous study conducted in Ghana wherein reasons were given, in support of present findings on utilization, in Ghana it has been estimated that there is one conventional psychiatrist for every 1.4 million people (Kpobi, Osei, & Sefa-Dedeh, 2014), and these psychiatrists are located predominantly in urban/peri-urban areas, the figures are similar, though slightly better, for other formal mental health professionals.

The participants in the present study commented that for cases involving mental illness caused by avenging spirits (*ngozi*), the Kore-kore believe that the only medicine is paying the required reparation (through ceremonies and exorcism), hence they have a saying "*mushonga we ngozi kuripa*" which means the medicine for the avenging spirit is paying the reparation (appeasement). Since the study established that mental illness is supernaturally caused, the reparation is done after all supernatural processes are done as indicated in the study findings. This is one of the

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major African beliefs which holds strong ground in many families. Along similar lines, an Asian study by Razali and Yassin (2008), shared a similar sentiment wherein it emphasized that mental illness is supernaturally caused, and that psychiatric patients attributed their illnesses to supernatural agents. They further illustrated that indigenous Malay medicine ascribes illness to supernatural causes which includes the activities of a wide variety of spirits, witchcraft, and the wrath of God. The treatment methods used by indigenous Malay healers include herbal remedies, ceremonial rites, incantation, exorcism and sorcery which share the same route of the Pfura Rural District.

The above converging ideas reflect that the traditional health practitioners adopt a ethnomedical/holistic approach in promoting mental health. Neba (2011), gives supporting evidence from a Cameroonian perspective, as he stated that the traditional healing art consists of two major elements that are often used in combination, the application of natural products and an appeal to spiritual forces. Natural products include extracts or decoctions from leaves, roots, oils, fats, animal parts or insects and appeals to spiritual forces involved incantations, symbols and sacrifices among other rituals. Therefore, traditionally most of the diseases as are referred to are caused by spiritual and supernatural causes.

In contrast to the above sentiment on mental illness, causes and beliefs, some school of thought attested that it is wiser and worthwhile for the traditional health practitioners to admit that there are also clinical causes of mental illness, thus the idea of collaborating the two is central. The undesirable or uncontrollable events have a greater detrimental effect, for example, work or family based issues, its different effect on people as well as financial problems or illness. Furthermore, the different characteristics of each instance in life alters how it affects the mind. So, the timing and circumstances surrounding a life event make a difference to how a person develops mental illness. Therefore, this different view on mental illness brings in the need for collaboration of the traditional and conventional system to work together in filling the gaps created by each.

Muleady-Mecham and Schley (2009), maintain that Western medicine focuses on scientific breakthroughs and cutting edge technologies which view the human body from a mechanistic approach for which medical malfunctions are fixed by altering or replacing the broken pieces unlike the ‘mind–body connection’ as a traditional element of ethnomedical systems fills this void. Although the ethnomedical systems are central to traditional medicine ethnomedical systems lack the division between mind and body. Many ethnomedical systems support a belief in a singular

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body force or 'bioenergy' as the source of human health, including the traditional systems of African medicine, Chinese medicine, and the Ayurvedic medicine of India

6.6. The referral of patients within the traditional health system.

The study discovered that there is a strong network between the traditional health practitioners themselves. The study also acknowledged the importance of medical practitioners in the chain of referrals. The study indicated that whenever they face challenges, the traditional health practitioners refer their patients to the next practitioner or to the medical practitioners for better attention and assistance. These findings are in support of the work of Kyeyune, Nakyanzi, Nkangabwa, Kabatesi and Tusaba (2000), as quoted in Zingela, Wyk and Peitson (2018), wherein an improved patient care with a referral system between traditional healers and biomedical workers in rural Uganda was noticed, with 98% of healers reported referring patients to biomedical workers one year after being trained in STIs and HIV, compared to 7% prior to the training.

In a Zambian study, a reason for the working together was noted due to educational sessions that the traditional healers received on various ailments such as HIV, malaria, TB, child health, and nutrition (Nyumbu, 2003). In most countries which recognize the traditional health promotion such as South Africa, traditional healers may refer formally to modern medicine, but the reverse is rarely the case. As described by Zingela, Wyk and Peitson (2018), there is a tendency in the Western oriented biomedical tradition to focus on the risks and play down traditional African medicine and the expertise of traditional healers although we cannot deny the drawbacks of traditional medicine, which include incorrect diagnosis, imprecise dosage, low hygiene standards, the secrecy of some healing methods and the absence of written records about the patients.

The present study indicated that the practice of referrals between traditional health practitioners and biomedical practitioners was collaborative; the clinics in Pfura can refer a patient to a traditional healer, and vice versa. This aspect of two-way referral was reported in South Africa as a catalyst and key to treatment adherence. The study done in Kwazulu Natal, South Africa that examined the acceptability and effectiveness of traditional healers as supervisors of TB treatment in Hlabisa, KwaZulu-Natal, showed that 89% of patients supervised by healers completed their TB treatment, in comparison to 67% of those supervised by health clinic personnel, community health workers or lay people (Colvin, Gumede, Grimwade & Wilkinson, 2002). The mortality rate among those supervised by traditional healers was lower (6%) in comparison to 18% in the other

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group thus promoting health of the rural people. Therefore, these consistent findings provide confirmation that not only can traditional healers provide an additional means of reaching patients, but through two-way referral they assist in improving treatment adherence and possible positive outcomes in chronic medical conditions. This may be another useful model to follow for possible collaboration between healers and medical health practitioners.

The collaboration of two health systems was also motivated by referral practices in Uganda, in a similar study which revealed that traditional knowledge in the health care system of maternal care was successfully used to combat high maternal mortality rates in which well-known and trusted system to aid mothers and babies during labor were used without the use of conventional methods (Miike, 2017). Moreover, the Traditional Birth Attendants (TBA) were given walkie-talkies within local communities to enable them to communicate with public health workers in case of emergencies. This simple technology of using walkie-talkies enabled the TBA to become the referral system to modern health care systems. In so doing, effective partnerships were formed between Western and traditional health systems.

Furthermore, casting away the myth and speculation that traditional health practitioners are not willing to join hands with the biomedical doctors, the present study findings in which traditional healers claimed that they wanted to find themselves having consulting rooms at modern health facilities. A South African study by Hlabano (2013), found that traditional healers said that some of their patients' problems were not within the scope of traditional healing and for their patients to receive proper heath care, most THPs said they referred them to western biomedical facilities. Across the traditional strong communities, studies have explored the willingness of THPs to work alongside biomedical practitioners and they have shown that THPs express a readiness to learn beyond their own healing system.

6.7. Christianity, herbalism and witchcraft in traditional healing

The study noted the most controversial topic in traditional healing in Africa. For instance, failure to understand the relationship between herbalism and Christianity. The present study noted that herbalists approved that herbalism is not a heathen practice as suggested by many. The present study therefore, established the Biblical scripture which supports that herbalism is not diabolical. The work of Chavhunduka (1996), indicates that many societies regard herbalism as anti-Christ. He states: "Historically many African traditional religious rites and rituals were regarded as against

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the Christian faith and morals. It was also believed that African religion promoted the belief in witchcraft and encouraged people to worship their ancestors instead of worshiping God". African medicine was regarded as unscientific and some of its treatment methods were considered anti-Christian. Traditional healers were regarded as heathens because of their participation in African Traditional Religion.

It is against this background that the current study established Ezekiel chapter 47: verse 12, "*And by the river upon the bank thereof, on this side and on that side, shall grow all trees for meat, whose leaf shall not fade, neither shall the fruit thereof be consumed: it shall bring forth new fruit according to his months, because their waters they issued out of the sanctuary: and the fruit thereof shall be for meat, and the leaf thereof for medicine*" (Version, 2017). To herbalists in this study, the above given Biblical scripture gave them power and audacity to practice traditional healing without the fear of being labelled as heathen. Furthermore, there is overwhelming support of this view from the work of Peirce (1999), who claims that there is no Biblical admonition forbidding the use of herbal products, and Christians should approach the herbal market from an informed perspective.

A study in Bostwana by Nkomazana et al., (2015), provides similar facts on the similarities and differences in the healing practices of Pentecostal churches and African tradition religion. The essay has indicated that while the traditional religions and Pentecostal churches are guided and ruled by different religious beliefs, there are striking similarities between their healing practices. Their religious beliefs are responsible for the differences. From the beginning both the traditional religions and the Pentecostal churches have laid great emphasis on health and healing. The essay has shown that healing practices in both the traditional religions and the Pentecostal churches have confirmed that African conviction is that spirituality and healing belong together and both revolve around religious protection and were consulted because they were believed to deal with spiritual forces to reverse misfortunes and heal a wide range of diseases and infirmities. The major attraction for both Pentecostalism and traditional religion is their emphasis on healing, a Pentecostal pastor, like a traditional healer, is accepted as the religious specialist and seen as a man of God anointed by the power of God to heal the sick.

Apart from the wide discussion given above on the similarities between Christianity and herbalism, on the contrary, this study attested that there was a thin difference between traditional healing

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specifically divination and witchcraft *(huroyi).* The study understood that the tools that the two use (a witch and a diviner) are the same, only for dissimilar purposes. Although few studies have touched on this area, Sugishita (2009) expresses the same sentiment from a Zambian perspective demonstrating that traditional healers (diviners) are characteristically oriented towards witchcraft and spirits, and the agents of affliction that constitute a real threat for many people today. In the same survey in Zambia it was postulated that such medicines are used not only to heal, as traditional healers do, but also to harm, bringing people illness, misfortune and evil spirits.

Along similar lines, Ehrenreich and English (2010) stated, "in addition to bad witches……

> *there were good witches who only cure the hurts that has been inflicted by bad witches explaining that of the two the more horrible and detestable monster is the good witches which is better known than the bad being commonly called wise men or wise women".*

From these given views, it can be concluded that it is difficult to separate traditional healing from witchcraft, the present study notes that this thin line between the two might be the reason why the colonialists named the practitioners witchdoctors.

Relating the present study to the above assertion about witchcraft and healing, the study establishes that much African traditional healing functions as a result of, and in reaction to witchcraft as a way of making sense of adversity. The present study suggests that witchcraft is a central parameter in the works of traditional health practitioners particularly the ones with divination. The diviners in this study emphasized the ethnomedical dimension which states that in general, illness is considered either God-made or man-made; this is true to the current day in southern Africa, where fear of witchcraft is still a factor driving the social, cultural, and religious intellectual system of Africans. A study by Ashforth (2005), sheds more light by asserting that anger from ancestral spirits who have been neglected or disobeyed can cause similar devastation therefore if traditional healer divines witchcraft as the cause of an illness, the traditional healer must fight against it, and must protect clients from future witchcraft attacks.

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6.9. The Challenges facing traditional health practices in the Pfura rural district

6.10. Traditional health practices have a low economic value

Despite the rising popularity of traditional health promotion practices in the Pfura rural district, the practice, still has to come out of the shadow of credibility and confidence. The challenges facing the practice and practitioners lies at the heart of the discussion in this section. The study revealed numerous challenges and impediments, however only key hindering factors will be discussed. The study revealed that traditional health practice has a lower economic value/profit to the practitioners considering the little income they get. The reasons cited for low income was that the pricing of practice is not standardized and regulated as it is done in the conventional sector.

The study therefore noted an assumption to this by pointing out that it might be because of poor socio-economic status of consumers which is associated with unemployment and low or poor income. Traditional health promotion relies on the local resources and it will be an advantage to adopt a standardization of pricing, because of its affordability. It will favorably assist in the striving economy especially in low income countries like Zimbabwe most modern health facilities are inaccessible for much of the population. In some urban areas, the average waiting time at a hospital or clinic can be as much as 8 hours with poorly trained and unmotivated staff. Most of the modern treatments are divorced from the patient's culture, family and community as patients are removed from the family and community, stripped of their identity and forced into a sterile hospital setting. The treatment only addresses a patient's biological manifestation of the illness and does not attempt to heal spiritual aspects of illness. Despite the low income that traditional healing can bring to the practitioner, if standardized it can sustain the health care in the midst of failing economy because of its affordability and holistic approach.

Given the paucity of published work on the issue of income and traditional practice, informed by the findings of this study, poor profits can be attributed to the consumers who are generally economically disadvantaged. Oyebode et al., (2016) on the logical grounds of economic hardships claims that in low and middle income countries where the number of practitioners of modern medicine may not be enough to meet the health care needs of the country, traditional medicine and its practitioners are considered an important resource for population health with some offering it for free. Therefore, this buttresses the popularity and boosts the perceived idea that traditional medicine is more affordable, accessible and acceptable to the poor communities

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in which it operates. The contributions made by traditional medicinal knowledgeable healers in local health care practices are important as their knowledge helps to produce therapeutic healing properties from medicinal plants, animals and minerals however the low economic return can be attributed to issues of bio piracy which many nations have failed to address.

According to Meetei (2016), bio-piracy and implications of Trade Related Intellectual Property Rights for the third world countries like Zimbabwe are the two greatest threats to their knowledge and survival means. Under World Trade Organization (WTO) regimes patents and copyrights are awarded to people and organizations to protect their creative and innovative inputs into products and processes. The Western Intellectual Property Rights (WIPRs) regimes has divided the North-South inequality in terms of economic development and this monopoly has brought the third world countries to face the problems of survival crisis as most indigenous people depend on their immediate biodiversity. The term bio-piracy is referred to the unauthorized use of biological resources such as medicinal plants, animals, micro-organisms, genes and indigenous traditional communities' knowledge of biological resources by big transnational corporations and global pharmaceutical industries (Amechi, 2018). Most of these bio-resources and knowledge are found in the third world developing countries like India. The fact is that more than 90 per cent of the world's biodiversity is located in African, South American, and Asian indigenous communities which have nurtured and developed such knowledge are less compensated for their native knowledge, which is taken from them.

The present study has proven to have given new idea around the pricing of traditional health services. Given little information on the subject, the study demonstrated that the profit of the practice usually was an issue among herbalists and traditional birth attendants who practised due to mentorship. The practitioners who are spiritually called, testified to a different reason suggesting that it is culturally wrong to price the traditional healing services. Therefore, it can be concluded out of this sentiment that, the low profit can be attributed to cultural beliefs and norms of the Kore-kore people which states that the spirit is there to take care of its people therefore the payment is usually in kind (for example, a chicken, or a cow). A study in the Asian communities supports the present ideas as they claimed that although many people have received appreciation through large amounts of money and gifts, the minority of participants maintained that indigenous healing was not there for sale but to render affordable and culturally appealing health care to the people (Ishak & Nassuruddin, 2013).

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6.11. Poor professional development and regulation

Poor professional development and regulation was established as a stumbling block for traditional health practitioners, especially for those who practice it for a living, thus expecting money. The study provided overwhelming evidence for the notion that the boards (ZINATHA & TMPC) which certifies individuals to become traditional health practitioners do not monitor them, hence giving ground to quackery and fake practices. Previous studies in Zimbabwe shared the same sentiment that, during the early 2000s there was increased public outcry regarding the conduct of traditional healers when the so-called spirit mediums and faith healers would witch-hunt individuals in public thereby causing pandemonium and fiasco (Duri, 2017). There were also reports of malpractice whereby some herbalists were using the same razor blade for a number of patients. This public outcry thus compelled the government to revisit its blueprint that was now gathering dust, and led to the appointment of the Traditional Medical Healer's Council that was reporting to its registrar but update as revealed it's the present study no yielding results have been noted.

The training in different health courses like TB and HIV and AIDS was reported to be insufficient. In a similar study, poor professional development and poor training of traditional healers was noticed in Mozambique with its implications on health system. Audet et al., (2015) put forward the importance of training by attesting that for a quality service delivery traditional healer should have the knowledge and skills to effectively, identify signs and symptoms of diseases, educate, assess serious side effects, counsel patients about safer strategies for partner disclosure (with assistance if needed, advocate for quality health care). In South Africa too, they called for professional development and training for in a fight against fake traditional healers citing that due to poor regulation it is impossible to differentiate between bogus healers and legitimate healers who received proper training (Street, 2016).

The traditional healers in the Pfura rural district condemned a huge number of healers who are not registered with any association and only deal with patients daily which then puts the name of the practice into disrepute. The commercial which hunter reported as the tsikamutanda has robbed families of their values in the name of traditional healing. This practice was condemned, and it was reported to be as a result of poor regulation and monitoring of traditional health practitioners in Zimbabwe. The importance of registration was demonstrated in an evaluation of the modern allopathic medical training model for healers in rural Nepal, revealed that the

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registered and trained healers maintained knowledge about the causes, prevention, and treatment of HIV/AIDS, increased referrals to health posts, and improved relationships with government health workers (Poudel et al., 2005).

6.12. Nonexistence of scientific research and assistance

The idea that just because traditional medicine products come from natural sources, they are completely safe, is dangerously false. Thus, most traditional health practitioners in Pfura demonstrated a need for scientific assistance to ensure authenticity, quality and safety. The scientific research assistance would assist them in experimenting with some of the herbs that they think are available to cope up with new illness, for example, cancer, however it is difficult due to lack of clinical trial. Rasool et al., (2017) argues that many plant species indicated for treatment of diseases have not been subjected to scientific methods of investigation, and the confirmation of their medicinal activities could be a decisive lead in development of treatments of present or future diseases.

Given the popularity of traditional medicine, it is therefore plausible for it to demonstrate that its products are both safe and of high quality through proper authentication process. However, a lack of scientific approval is delaying practitioners and hindering them to deal with the burden of current diseases. In a similar study by Hosseinzader et al., (2015), a lack of scientific research for herbal clinical trial was reported given that most of the reported side effects were associated with the use of traditional medicines. The challenges were identified to be extrinsic to the product itself, arising instead from errors in plant identification, poor manufacturing practices and lack of product standardization, contamination of products, substitution or incorrect preparations or dosage thus clinical approval becomes paramount (Hosseinzader et al., 2015).

As an endorsement to the point above, Xutian et al., (2015) argue that the existence of scientific assistance will make risks relatively small and traditional medicines will be used correctly to enhance consumer understanding. Furthermore, a cross-sectional population survey conducted in Australia found that less than half (46.6%) of traditional, herbal practitioners were aware that there could be potential risks associated with product use (Adams et al., 2015). Reading from these findings of the given Chinese and Australian study, one can suggest that in China and Australia the traditional health practitioners receive a better scientific assistance to ensure authenticity, quality and safety of herbalism, unlike in Africa, with special reference to Zimbabwe.

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Unlike Africa, America has shown the effectiveness of scientific assistance regulatory policies can effectively protect their citizens from the identified problems. It is out of scientific research that in America, herbal products are regulated as dietary supplements in the United States, and are therefore not subject to most of the requirement that proprietary drugs must meet before they can enter the marketplace (Job et al., 2016). This type of intervention can assist to set aside the media speculation that it is not safe, as shown in the present study wherein they also condemn that despite poor safety of herbal drugs, the media is also speculating false information, the reason being that lack of research will directly affect the authenticity of the practice and services.

Given the above discussion it is cogent to note that there were also a minority of traditional practitioners who regarded research assistance with suspicion. The present study has shown that the suspicion was born out the deep-seated hatred of the black people towards scientific methods which they believe originated from the West. This suspicion was further illustrated by Sugishita (2009), who did an investigation of this kind in Zambia, wherein a great deal of mistrust between traditional healers and scientists collaboration projects almost failed, according to a scientist involved, traditional healers refused to specify the ingredients of medicines that they had provided for chemical analysis.

In this regard, it appears as that, traditional healers are regarding the scientist as not so much a cooperator, but a competitor who might steal their knowledge of medicines. This study acknowledges that there is need for researcher to orientate the traditional health practitioners about the essence of conducting research and to outline the interest it serves. Proper orientation is necessary as we can see the age of the present study participants can be traced back to the period of the Zimbabweans who suffered a lot from colonialism. This mistrust and suspicion between the two systems is also linked to poor documentation of traditional health practices as discussed below.

Given a likelihood of mistrust between western and African healing systems, in a contrary view a Chinese study revealed that biomedicine and Chinese medicine also have some kind of healer practice. Medical practitioners of Chinese medicine and biomedicine have shared their knowledge and techniques, both biomedicine and Chinese medicine have formed the accumulating healer practice (Maciocia, 2015). In this sense one can conclude that Chinese traditional medicine should be therefore categorized as accumulating healer practice if we compare Chinese medicine

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with other types of folk medicine in which healers often do not have common knowledge or techniques for medical practice.

6.13. Poor documentation, age of practitioners and extinction of traditional health practices

The study noted that the knowledge of herbs and traditional health practices relies much on oral tradition and it is prone to face misrepresentation and grave risk of extinction. A study in Nigeria consistently supported that oral tradition made it nearly impossible to fully exploit the indigenous knowledge to the advantage of all the people due to among other things, failure to document it properly, and this has resulted in failure to locate and utilize it (Ebijiwa &Mabawonku, 2015). It is therefore cogent to properly document indigenous knowledge (to be discussed in the next chapter) and revolutionize healthcare system at the local level for the betterment of existing and future generations. The current study covered the aspect of age of practitioners as a setback in the sustainability of the traditional health practice, most them are over 60 years of age that then give them difficulties in carrying tasks like going into the forest to identify herbs and process them. However, in this study a strategy to ageing practitioners was given (to be discussed on the next chapter). Judging by the age of the participating traditional healers, it would seem likely that the younger generations are not taking interest in the practice of traditional medicine, further suggesting that information base is gradually eroding.

The present study puts across that not only poor documentation but factor like the ageing practitioners and settlement is destroying the system slowly, day by day. Urbanization and settlement have destroyed many habitats of precious animal and plant species that can be used for traditional healing in Pfura. A study by Da Nobrega Alves (2008) claims that worldwide, extinction is real, given that reptiles which are used in many countries and communities for therapeutic purposes, involving snakes, tortoises, turtles, crocodilians, and lizards. Of considerable concern is the fact that just over half (53 %) of these animals are on lists of endangered species. Given this sad scenario, it is important to note that the traditional healing is impeded as some traditional therapies rely on these animal products. In a South African study, it was validated that not only human activities are a contributory factor to extinction, environmental factor such as land degradation through soil erosion and pollution should not be spared (Magoro et al., 2010).

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In this regard the aspect of bogus and inexperienced herbalists were condemned due to their behaviour of harvesting the natural herbs, which is done at an exhaustive rate without replacement thus herbal sustainability is compromised. According to Kamana (2017), the practice of traditional medicine within Africa is at risk of being lost due to the impact of colonization. Displacement of people from traditional lands as well as changes in family structures affected passing on of cultural knowledge are two major examples of this impact. Prior to colonization traditional forms of healing, such as the use of traditional healers, healing songs and bush medicines were the only source of primary health care.

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Chapter 7

7.1. Recommendations and Conclusion

7.1.1 Introduction

The study explored the role of traditional health practitioners in promoting health in the Pfura rural district council. The study revealed that traditional healers play a pivotal role in ensuring that the primary health care of the rural folk is met. In recognizing the widespread reliance on traditional health medicine and the central role it plays in many communities, the study recommends the following.

7.1.2. Recommendation to practice and communities

The first recommendation from this study is that integration of traditional medicine into national health systems in combination with national policy and regulation for products, practices and providers is key (see Detailed framework Figure 3). It is a responsibility for health promotion in health services to be shared among individuals, community groups, health professionals, health service institutions and governments. The present study recommends that in the Zimbabwean scenario, institutions must work together towards a health care system which contributes to the pursuit of health. The reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This will lead to a change of attitude and organization of health services which refocuses on the total needs of the individuals.

In the same line the present study recommends the embracing of the goals of the WHO strategy 2014-2023 second objective which is to promote the safe and effective use of traditional medicine through regulating, researching, and integrating TM products, practitioners, and practice into main health systems. Moreover, this recommendation is also to build hope and success upon the Beijing Declaration of November 2008 (Stafford, 2010) which recognizes and emphasizes the integration of traditional medicine into national health systems of any country. The role of the general public and health care consumers has to be acknowledged, taking into consideration the impact that modernization, education and socio-political changes have had and continue to have on health-seeking behavior, as well as

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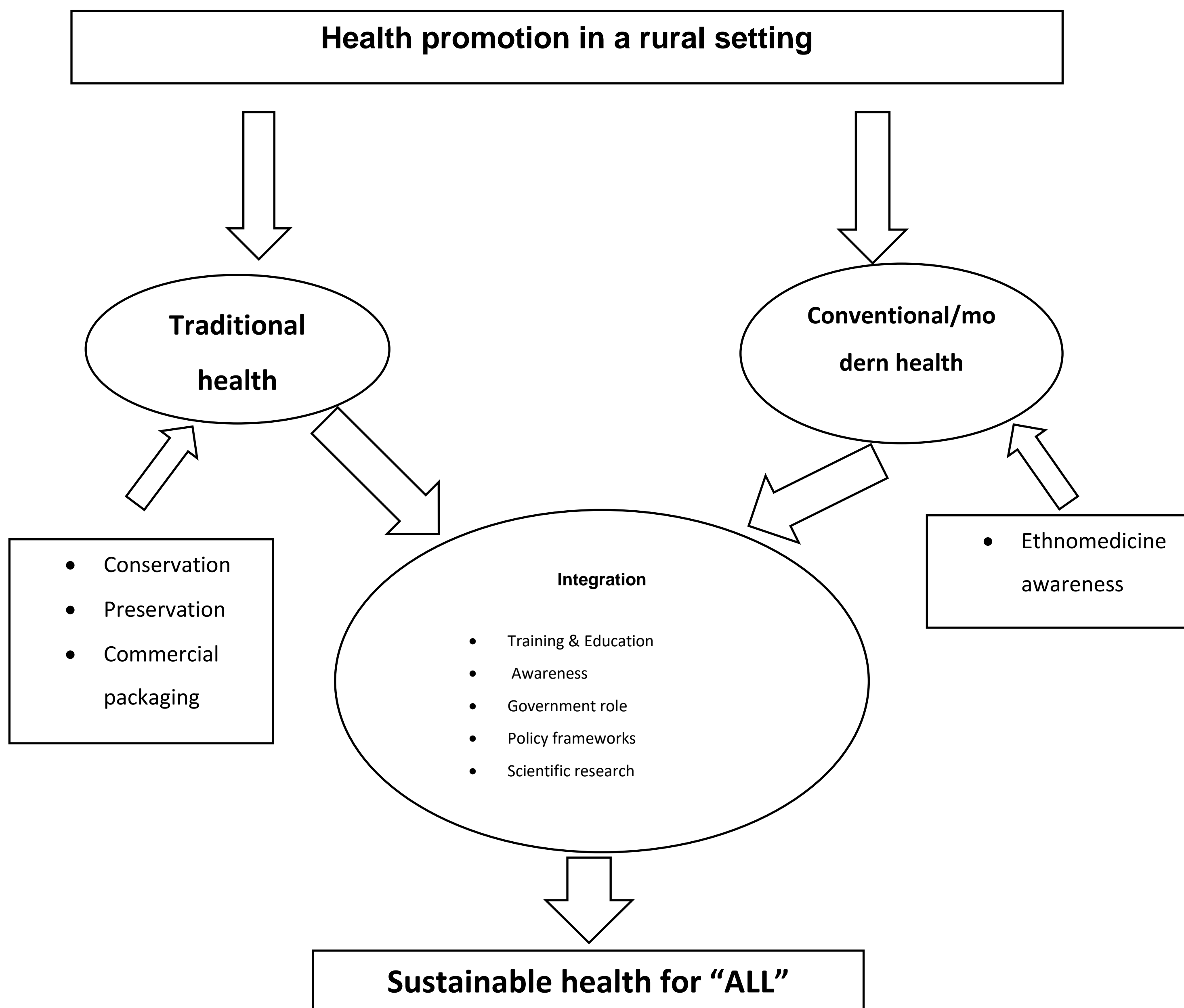
recognizing the freedom of choice in health care as guaranteed by the Constitution. A statutory body similar to the Health Professions Council of Zimbabwe should be established. Its functions would include the control over training, registration and practice, specification of entry requirements into the profession, maintenance of a register of bona fide healers, establishment of a code of conduct and provision of penalties for practicing while unregistered.

Figure 3. The framework for sustainable traditional health promotion in a rural setting



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The study emphasizes and supports personal and social development through providing information, education for traditional health. By so doing, it will increase the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health. Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness in the midst economic hardship which is affecting the health funding system.

7.1.3. Policy recommendations

The study recommends the development of health promotion policy which combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. The policy development should be a coordinated action that leads to health, income and social policies that foster greater equity and more joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments. The Department of Health and Child Welfare in Zimbabwe should take the lead in the formulation of policies.

7.1.4. Creation of Supportive Environments

Acknowledge traditional medicine as part of primary health care, to increase access to care and preserve knowledge and resources. However, given the complexity of traditional health promotion and interrelated issues, health cannot be separated from other goals. The inextricable links between people and their environment forms the basis for a socioecological approach to health. The study recommends systematic assessment of the health impact of a rapidly changing environment, particularly in areas of technology, work, energy production and urbanization is essential, and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be discussed in any health promotion strategy.

7.2. A framework for a sustainable and integrative health promotion in a rural setting.

> *"It is important to remember that acknowledging a practice does not necessarily mean you are endorsing it!" Adolf D. Woolf (2003).*

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The study therefore calls for a complete inclusion of traditional health promotion given that in Zimbabwe the overwhelming majority population is African, yet western medicine is the officially accepted approach to, and standard of care. The World Health Organization (WHO) has supported the medical integrative model since 1978 during its Alma-Ata Declaration, urging its member countries to incorporate traditional medicines into their national health care systems (Sato, 2012, Sarmiento, Zuluaga & Anderson). The present study recommends the strengthening of relations between traditional healers and modern medical professionals through better communication and cooperation.

Despite the World Health Organization recognizing the potential of traditional medicine as an adjunct of western medicine, especially in the fight against AIDS, in any case, the need for trans-cultural health system is necessary in Zimbabwe and the majority of the study participants agreed that effective communication between traditional and allopathic medical providers via cross-referral of patients has the potential to facilitate the smooth integration of alternative medicine into the mainstream health care delivery system.

The national health care system of Zimbabwe is based entirely on biomedicine, traditional health promotion is only tolerated or legitimized by the law, however little is given to the latter which millions of people are relying on during this period of economic hardships. Building bridges between health care systems remains the surest way to actualizing a robust health care delivery system for the resource-poor and the underserved in Africa, and Zimbabwe, in particular.

The WHO (2017) has defined three types of health systems to describe the degree to which traditional health is officially recognized part of the national health system. The first is integrative systems in traditional health system is officially recognized and incorporated into all areas of health care provision. The second is inclusive systems, which recognizes traditional, but has not yet fully integrated it into all aspects of health care. The third is tolerant systems, which is in Zimbabwe, the national health care system is based entirely on biomedicine, but some traditional health practices are tolerated by law. The health polices in Zimbabwe presently do not acknowledge the possibility of traditional medicine to form part of the national health system.

The Traditional Medical Practitioner Act of 2007 (Mafuva & Marima, 2014), focuses only on registration, regulation and monitoring of traditional health practitioners. In this study, traditional and modern practices are to be integrated as two branches of medical sciences with the ultimate

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incorporation of elements of both to form a new branch of national health care system. The need for collaboration between traditional and biomedical practitioners is also highlighted when traditional practices negatively affect public health delivery efforts. Muula et al. (2009) studied a sample of 720 mothers of children five years old or younger in Pont-Sonde, Haiti to investigate the relationship between traditional medical care and child vaccination status. The findings were that children of women who often or always sought care from traditional healers were 53% less likely to be fully vaccinated than were children whose mothers never used traditional healers.

In support of the present framework for sustainable and integration the researchers concluded that these results highlight the importance of collaborating with traditional healers to encourage them to support biomedical interventions that improve the health of their communities In spite of the World Health Organization’s recommendations over the past decades, Ghana features a pluralistic rather than truly integrated medical system. Policies about the integration of complementary medicine into the national health care delivery system need to account for individual level involvement and cultural acceptability of care rendered by health care providers. Studies in Ghana, however, have glossed over the standpoint of the persons of the illness episode about the intercultural health care policy framework (Gyasi et al., 2017). A practical reference can be made to the one of Vietnam, China and India who improved the health care access, reduced inequality gap by developing a unique integrative health care system through standardizing. The evidence from these populous nations suggests that an integrated approach to health care leads to safer, faster and more effective health care for the underserved communities with fewest resources.

The idea of integration of the two health practices has been suggested in many countries in Africa, but so far, traditional healing still be legitimized only, but not included in the health care system, however millions of people rely on it for primary health care. As highlighted earlier on traditional health promotion in Zimbabwe are only tolerated by the law and they only ran parallel to modern health systems. Integration is possible in Zimbabwe given the, inter-provider communication in a form of cross-referrals and collaborative mechanisms between healers and health professionals which often occurs but remains unofficially sanctioned.

Given the level of skepticism and mistrust between the traditional healers and modern health care professionals which might be due to inadequate political commitment to inclusive awareness, the

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practitioners require an opportunity to undergo training for integrative medical practice which introduce them to the diversity of healing approaches and techniques. The framework entails the importance of ethnomedical approach enlighten the modern health practitioners about the traditional medicine. As indicated earlier, ethnomedicine refers to the study of traditional medical practice which is concerned with the cultural interpretation of health, diseases and illness and addresses the healthcare seeking process and healing practices (Addy, 2017). The approach constitutes the use of plants, spirituality, and the natural environment and as a source of healing for people.

Gyasi et al., (2017) explain that integration can be managed at the individual level, involving patients, traditional healers and biomedical health professionals; the institutional level, at health centers and hospitals; and at the societal level, involving the government policy framework. In the process of including all these levels in the framework of integration for sustainability, the work of De Lange (2017), emphasizes the role of the government which will be discussed in the subsequent topic, which is central in the abolishment of some policies and Acts which conform to practices analogous to colonial health system.

Supporting the sustainability through integration of two health systems is central to this discourse given its great potential to improve people's health and wellness. It is an important, as it is often seen as more accessible, more affordable, and more acceptable to rural people and can therefore also be a tool to help achieve universal health coverage. 80% of the population of Zimbabwe lives in the rural areas. With the integration, the rural folk will be given an option and choice for primary health care. The integration will give the Zimbabwean health system more economic independents from the global fluctuations. The affordability of most traditional medicines makes them more attractive at a time of soaring health care costs and widespread austerity.

However, given the history of mistrust which dates back to the time of colonization, wherein Christianity, traditional medicine and modern medicine clash, a lasting sanitizer is key. The sanitizer or the chlorinator for this clash as given by the framework is awareness through policy formulation where in the people are given the choice to choose. In this model, an argument could be made for the state to finance or at least subsidize care provided by traditional practitioners so as not to prejudice those patients choosing traditional medicine. However, it must also be pointed out that at a time when modern health care services are already hard pressed to provide even basic care in an adequate fashion, the drain which could occur through financing traditional

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healers could have detrimental and unacceptable effects on the modern sector In stressing an integrative system in this guide is an officially recognition and incorporation of traditional health practices into all areas of health care provision. Guided by country's national drug policy; providers and products will be registered and regulated and therapies will be made available at hospitals and clinics (both public and private).

The benefits of integration may include the inclusion of indigenous herbal products in the national drug list, deployment of better technologies in traditional medicines practices, development of new drugs for orthodox use, exposition and censuring of myths which cannot be scientifically substantiated, empowerment of the local populations who are farmers and custodians of these medicinal plants and knowledge, development of medicinal plant plantations and creation of mass employment. The study envisaged benefits of the co-operation option would include the following: an increase in healers' medical knowledge with a consequent reduction in harmful or even fatal outcomes, an enhancement of inter-personal skills on the part of Western-trained doctors by acknowledging the cultural context of their patients and freedom of choice for health care consumers with safe options being offered in both sectors.

Mindful of the traditions and customs of peoples and communities, both systems consider and support disease prevention or treatment as well as health maintenance and health promotion. Shoko (2018) gave a good account that can be related to the event of a Harare traditional practitioner who has been widely publicized as administering HIV and AIDS therapy at the Immunity Enhancement Centre in the Avenues in town. He uses bio-medical drips to strengthen blood and recommends Western food rich in vitamins and wheat porridge for good health, but he also maintains traditional foodstuffs such as *rapoko, sorghum, millet,* ground and monkey nuts, vegetables and wild fruits make up good healthy diet. He disburses drugs with traditional medical ingredients to combat thrush, the result of severe infections. This supports the notion of integration wherein both practitioners admit to and learn their shortcomings; hence working together for health for all is key.

7.2.1. Government role and policy formulation

In the policy development agenda, the type of leadership of certain country is a determinant. However, the frequent change of government policies in a given nation will contributes to ease

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in integration of TM in the health care delivery system. The present legislation and regulations of Zimbabwe exclude traditional health practitioners from operating in the same space as modern health practitioners. A notion that the Traditional Health Practitioners Act of 2007, paved the way for the integration of traditional health practitioners and modern health into the national health care system is premature and possibly misguided. It is the role of the government department in this case, we include ministries like, Judiciary, Environment, Health, and education which will be central in the drafting of policies that support integration. At this level the governmental commitment is crucial as it is the highest office in the adoption of any policy.

Government should ensure stability in governance and continuity of policies in TM development and integration. The government role will be spearheading the drafting policies and bills with respect to formalizing and integration traditional health promotion practices into the health care system. Traditional healing is not properly regulated; it allows anyone to practice as a healer without question which in turn bring a mistrust from the modern health practitioners. The policies in regulation, will included the regulation of practitioners as well as the resources of the traditional health. In the developed policies and regulatory frameworks, there is a need to evaluate their effectiveness and identify ways in which challenges regarding practice and practitioner regulations can be addressed by benchmarking against appropriate reference standards.

The Alma-Ata declaration on Primary Health Care (PHC) by the World Health Organization (WHO) in 1978 saw a response from several countries to improve their traditional medicine use and regulation of use within the primary health care model. The principles of PHC will therefore be the basis in the development of policies of control and regulation and these principles includes effectiveness, affordability, use of proper technology, and research. The study established that traditional health services are often unregulated which might result in unacceptance by the modern health care sector. After a policy is put into place communities will become more accepting of both modalities and both modalities will be safe and effective to use. There will be freedom of choice amongst people and neither modality will be able to criticize the other, because they will both be fair, ethical and regulated. The study indicated the mushrooming of quackery practice of the tsikamutanda/witch-hunters which clearly indicates the number for strong regulatory polices to eliminate charlatans, impostors and unscrupulous practitioner who are currently a contributory factor to full integration.

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7.2.2. Education, training, and awareness

The introduction of courses in TM into the curriculum of undergraduate, postgraduate and professional continuing education, may correct the anomaly of mistrust. The study of ethnomedicine and the diverse belief systems of traditional healers, versus that of their Western biomedical practitioner counterparts, regarding illness perceptions and definitions, will assist in the efforts of therapeutic integration. These students will be mentored into herb identification, processing and administering as well, as taken through some ritual and spiritual orientation to promote the traditional healing to posterity. In these proposed schools the traditional healers will play an active role in educating the youth about African traditional health practices and how important it is to preserve these practices and the damage done through political and religious interference will be halted.

Further support is needed from organized modern medicine, including a change in the medical university curriculum. Emphasis is to be placed on primary health care and its underlying philosophy of promotive and preventive care and community participation. Elements of traditional medicine need to be integrated into the syllabus. Consultations with healers should take place when required. Given that, establishing training school, can be possible to have authorities approve, further the study puts forward that traditional health practices should be incorporated in the context of the evolving scholarship. This attempt will enhance the modern health practitioners to understand the real cognizance of traditional medicine, thus developing an interest and foster and embrace it as a practice in the national health system. Given the importance of human rights principles and a human right and its application to all aspects of traditional healing training of practitioners will include the aspect of ethical consideration and conduct which is the current problem affecting the image of traditional medicine in Zimbabwe. The training colleges and schools will also assist in the scholarly and proper documentation of traditional health knowledge which is now relying more on oral tradition.

The establishment for both traditional and modern academies will offer intensive training at appreciable levels that are verified by the national qualifications frameworks in order to cope with emerging health trends. These appropriate colleges for both practitioners will foster professionalism which is key for health promotion sustainability. The case scenario for Vietnam shows how training aids the implementation of a register of vetted practitioners who can easily be tracked and cancelled from the register in the event of malpractices and proper training ensures

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that the public is not misled by some scrupulous self-proclaimed traditional and faith healers who may claim to treat some illnesses in a bit to enrich themselves (Ngueyen et al., 2016).

Both the traditional and modern practitioners need to be educated in TM and the integration process. The traditional medical practitioners should also be trained in modern good/best practices such as good hygiene, good agricultural/propagative practice, good clinical practice, good manufacturing practices, and other training that could widen their knowledge on diseases and how they could improve on their method of diagnosis, treatment and preparation of remedies. The orthodox practitioners should also be taught on useful aspects of traditional health. There should be an awareness campaign to enlighten and guide the public towards changes in the existing pattern. The educated practitioners should be encouraged and given the necessary supports. Developing and introducing traditional medicine into the curriculum of all Medical school in the country. This will help train and sensitize young orthodox medical practitioner on integration and sustainability.

7.2.3. Packaging and Promotion Strategies

The framework given in Figure 3 shows that the traditional health practices are to be improved before integration, these aspects of improvement includes packaging of herbs for international. Although there are generally some form of restriction on the kinds of promotion allowed for healthcare products, a better strategy to educate the public on their use and the packaging of herbs as dietary supplements as obtained in the US and EU countries may change some perspective about traditional health promotion hence sustainability and integrative possibility. The framework illustrates that packaging of herbs especially for the ones which do not need sophisticated processing, can be done in a more appealing way like the Chinese and Japanese. The drug policies in Zimbabwe should incorporate the traditional herbs as they are from an African perspective, wherein they will be a clause that allows traditional healers to package their own medicine for the market. Currently the policy does not cater for traditional herbs and products, it only protects the modernized products.

7.2.4. Standardization of traditional health promotion through research and validation

The guide recommends that for a sustainable integrated health promotion strength, knowledge generation, collaboration, and sustainable use of traditional resources, including intellectual

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property and natural resources is crucial. Scientific research will strengthen quality assurance, safety, proper use, and effectiveness of traditional by regulating products, practices, and practitioners. However, the validation of traditional practices should not be only through modern sciences, the traditional practitioners will be also be given their chance to ascertain and validate some products and practices in an African and traditional way. The process of validation should not treat TM as inferior to modern health but should be able to give a chance the TM practitioner to prove their way of validating their products for efficacy, efficiency and safety.

7.2.5. Preservation and conservation of traditional health promotion

Since herbal medicines are now used internationally, products often used in parts of the world other than that in which they were originally grown, developed, or manufactured. This highlights the importance of considering different legislative frameworks as shown before and ensures that information on quality and safety is shared so that products are used appropriately. This therefore brings in the issue of intellectual property. A traditional health specific IPR (Intellectual Property Rights) policy should be developed that will guarantee adequate protection and compensation for intellectual property of indigenous traditional medicine practitioners. A scheme should be put in place to sensitize and encourage the health system to embrace the IP (Intellectual Property) policy that would be developed. The World Intellectual Property Organization argues that there is need to protect indigenous or traditional knowledge from exploitation for financial gain by third parties (WHO, 2017).

The drafting of financial plans which favor and promote both parties, is the central area of departure. Advocacy in financial strategies will be drafted and submitted to authority for urgent investment and support of traditional healers and traditional medicine not only by government, but also by civil society and the private sector. The aspect of ensuring protection or getting benefits to property rights owners where such rights are divulged are yet to be totally solved and it clear the suspicion and mistrust between traditional health and modern health. This clearly suggest that the traditional health will also benefit from the health care funding systems.

Traditional healing is also spiritual, that is driven by ancestral spirits, in an African culture these spirits need to be celebrated from time to time to keep them informing the practitioners about the problems facing the people. The guide therefore recommends that these ceremonies should be upheld from time to time so that the practitioners they don’t lose connection with their ancestors.

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With polices in place the endangered plant and animal species which are rich in medicinal purpose through the establishment of local sanctuary, given land by the Ministry of lands as suggested through government role to propagate and preserve these species to avoid extinction. This strategy calls the multisector approach which means that stake holder which includes the environmentalist, THPs, Ministry of Health and Judiciary will be responsible in the drafting of guidelines and polices that will assist in preservation of endangered animals and plant species which are for medicinal purposes.

Proper handling and sustainable use of medicinal plants should be encouraged to ensure that materials are collected from the same environment to mitigate variation in material constituents that could arise from environmental variation. Thus, in addition to programs and guides being put in place for practice regulation and control, product quality control, a biodiversity conservation programme should be developed and the TMPs sensitized and trained to support such programs. The traditional health practitioners should be trained on sustainable collection, harvesting and use of medicinal plants and other natural raw materials use in their practice. Biotechnology should be deployed to support the standardization and conservation process. The method of preparation (extraction, decoction, maceration, infusion) must be generally acceptable and standardized by all practitioners.

8. Contribution to the body of Knowledge

The study objective was to expose the role of traditional health practitioners in health promotion in a rural setting of Zimbabwe. The area of study is unique with its poor economic development which has few clinics and the road networks under-developed. Not only is the place underserved by biomedicine, but little known research in this small area of the Pfura district has been done to establish the role of traditional health practitioners in promotion of the health of the rural folk. However, the present study established and shared the same wider quotation from across the globe, which says that 80% of the population particularly the rural folk, rely on traditional medicine for primary health care. Furthermore, the study findings from this area can be used for comparison to other areas with same characteristics for solution to challenges facing traditional health practice.

The Word Health Organization and her sister organizations in health has been known for a longer period in establishing research on traditional medicine, however studies have shown that most

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reported issues are based on National health reports. Most reported issues are found to be based on desktop researches and experimental research, mostly on herbal efficacy, not the practice of traditional medicine. The qualitative using one on one in depth contributed to the body of knowledge as an important mode of inquiry. The study adopted a descriptive, explorative and qualitive approach conducted case stud in rural, it envisaged that the study findings are reliable due to the adoption of one on one in-depth interviews with registered traditional health practice.

Despite the pressure from the national health policy that promotes biomedicine, traditional medicine is still the major source of health care service for many patients. Two factors could be identified which made traditional medicine persistent despite the absence of official technical and financial support to healers.

The first is that traditional medicine remains the source of culturally appropriate therapy for the illness that biomedicine does not recognize their relevance such as illnesses of personalistic origin. In achieving this most important part of traditional health practice, the present study used an approach which appropriate for such an area of study. The study approached health from an IKS perspective contributes to the current scholarship trends. The Afrocentricity theory of social change and ethnomedical approach formed part of the theoretical approach of this study. The use of both a conceptual and theoretical framework can also be seen as an important methodology in having a deeper understanding of issues in these underreached area of indigenous knowledge systems.

Secondly, the dissatisfaction with treatment outcomes at anyone of the biomedical clinics or hospitals pushes patients to consult traditional healers and hence contributes to their persistence. Informed by the study finding of the present study a framework for proper integrative and sustainable health promotion was developed. Although many researchers have put forward many suggestion foe either tolerant or incorporation of two health systems, the present study manage to align factors that can contribution to a complete integrative health system. In the same regard the study outlines some issues relating to practices that are hindering the complete integration of the two health systems. This idea is one of the crucial one given the economic breakdown which is affecting the health financing system of many countries particularly in Africa.

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9. Conclusion

The present qualitative study, using in-depth interviews explored the role of registered traditional health practitioners in promoting health in the Pfura Rural District Council, Mt Darwin Zimbabwe. The study revealed a high popularity and utilization of traditional health practices that sustain the primary health care of the Pfura rural population. Traditional health practices which include promotive and preventative as well as curative using natural herbs, animal protection and spiritual protection is part and parcel of the mechanisms to deal with illness for most of the people in the Pfura rural area. Despite marginalization and the absence of official technical and financial support, the traditional health practitioners have good practices such as referral practices, however it is still unsanctioned. The absence of governmental support in policy formulation to favor traditional health practitioners remains a challenge that needs prudent decision to tap the positive aspects of the practice to promote health for “All”. Several barriers to traditional health practices which exist are influenced directly or indirectly by the lack of governmental commitment to draft sustainable polices to reduce mistrust between traditional and biomedical systems. Although the study findings suggest a need for a proper integration of two health systems to be one, there remains insufficient political will power. Governmental policies and the weak institutional support, lack of regulation and training for practitioners and nonexistence of scientific research for safety and validation of practices has inhibited the sustainability of traditional health practice in Zimbabwe. The present rate of utilization traditional health practice together some good practices such as uncoordinated and informal referrals system justifies the integration. Given the importance of traditional health practice for the Zimbabwean people and economy, this study developed a guide which is made of strategies that can be adopted to assists in ensuring a traditional health practices for an integrative process from it to become part of the main national health system. The guide recommends that policy formulation is central as the departure point to realize proper integration of traditional health and biomedicine in Zimbabwe.

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APPENDICES

Appendix A: Proof of Language Editor

Dr Catherine Hutchings
Freelance Editorial Services

51 Bathurst Road
Kenilworth
7708
Cape Town
Western Cape
South Africa

Telephone/Fax: + 27 21 7618522
Mobile: + 27 82 9702219
E-mail: catherinehutchings@gmail.com

To whom it may concern.

I hereby confirm that I edited **Mambanga Pfungwa's** PhD thesis,

The role of traditional health practitioners in health promotion: A case study of the Pfura Rural District, Mashonaland Central Province, Zimbabwe.

in August 2019.

I wish this student well in their endeavours.

Catherine Hutchings

Dr Catherine Hutchings

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Appendix B: English Interview guide for the In-Depth interview

Section A: Profile of the traditional health practitioners

Village………………………

Level of education…………………………

Type of Traditional Practice…………………………….

Source of power/knowledge……………………………………….

Number of years in practice…………………………………..

Number of patients served……………………………………………….

Sectional B (CENTRAL QUETION): **THE OF THE TRADITIONAL HEALTH PRACTIONERS IN PROMOTING HEALTH**

- What are the indigenous health promotion practices in Pfura Rural District?
- What are the challenges facing traditional health practitioners?
- What are the strategies to enhance and sustain traditional health promotion practices in a rural setting?

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Appendix C: Shona Indavhiyu gaidhi

Chikamu chekutanga : Profile e chinyakare hutano practitioners

Bhuku ramunogara………………………

Mkadzidza kusvika papi…………………………

Rudzi rwe basa renyu Practice…………………………….

Nyuko dze simba……………………………………….

Nhamba ye makore mubasa…………………………………..

Nhamba ye varwere (mirwere) ……………………………………………….

Sectional bhi (b) Zvinoitwa nana chiremba vaechinyakare mukukurudzira hutano

- Ndedzipi mhando dzezvekukurudzira hwutano dzinowanikwa muno mudunhu rePfura?
- musangana nematambudziko api mubasa renyu?chii ri omisidza nanga chinyakare hutano practitioners?
- inzira dzipi dzingsa pedza matambudZika aya uye kuti hwurapi hwenchinyakare hwuenda mberi?

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Appendix D: Consent form

Department of African Studies, University of Venda.

February 2018

I am **MAMBANGA PFUNGWA** a post-graduate student pursuing a PHD in the Department of African Studies, at the University of Venda; invite you to participate in this study. I'm conducting a research investigating the role of traditional practitioners in promoting health. Your positive response will enable the researcher to draw conclusions from the findings and be able to give recommendations that can be helpful to the community who are consumers of the practice. As a participant on the research you will be entitled to your own privacy about your thoughts, beliefs and personal understanding. After the collection of data, the researcher will take responsibilities to maintain confidentiality of the information given by participants.

Signature of researcher……………………………….   Date…………………………

I ……………………………….. have read and understood the contents and terms of this invitation to participate in this study. I hereby declare that I am voluntarily participating in this research.

Respondent signature………………………………….   Date……………………………

Witness` signature………………………………………..   Date………………………………

For more information contact Mambanga P (Researcher)-0737823297 or mambangap@gmail.com

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Appendix E: Letter for seeking permission

University of Venda

P. Bag X5050

Thohoyandou 0950, Limpopo

South Africa

The District Administrator

Mount Darwin Pfura

District Council

26 March 2018

Dear Sir/Madam

Re: Seeking permission to conduct a study

I am a PHD student at University of Venda. In order to complete my degree (PHDAS), I am expected to conduct a research project of my choice.

As it is being observed that the costs of consulting medical care is increasing at an alarming rate. It is therefore plausible to shade more light on traditional health practices as majority are opting to use it as it cheaper, efficient and culturally appealing. In that regard I have decided to do a study which expose; The role of traditional practitioners in promoting health: A Case study of Pfura Rural District Council, where in the population will be drawn from Ward **X.** The data will be collected through in-depth interviews wherein the recorded data will be kept confidential.

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I am therefore requesting your permission to use the traditional practitioners in your area. I am of the hope that the findings of this study will, assist us in sustain the traditional practices for the benefits of the present and future generations.

Thank you're your cooperation and assistance

Yours Faithfully

Pfungwa Mambanga

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Appendix F: Ethical Clearance Certificate

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Mr P Mambanga

Student No:
11605743

PROJECT TITLE: **The role of traditional health practitioners in health promotion: A case study of Pfura rural district, Mashonaland Central Province. Zimbabwe.**

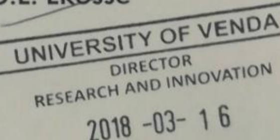
PROJECT NO: **SHSS/18/AS/01/1403**

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof VO Netshandama	University of Venda	Promoter
Dr P Matshidze	University of Venda	Co - Promoter
Dr TG Tshitangano	University of Venda	Co - Promoter
Mr P Mambanga	University of Venda	Investigator – Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: March 2018
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: ....
Name of the Chairperson of the Committee: Senior Prof. G.E. Ekosse



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Appendix G: Letter of permission to conduct the study

University of Venda,
Faculty of Human and Social Sciences
Department of African Studies
P. Bag X5050
Thohoyandou 0950, Limpopo
South Africa

The Ministry of Health
and Child Welfare
Pfura Rural District Council
Mt Darwin, Zimbabwe

17 April 2018

Dear Sir/Madam

Re: Permission to conduct a study

Referring to the above matter, I write to request your permission to conduct in-depth interviews to your registered traditional health practitioners. I am a PHD student at University of Venda. In order to complete my degree (PHDAS), I am expected to conduct a research project of my choice.

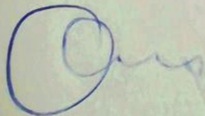
It is being observed that the costs of consulting medical care is increasing at an alarming rate. It is therefore plausible to shade more light on traditional health practices as majority are opting to use it as it is cheaper, efficient and culturally appealing. In that regard, I have decided to do a study which expose; "The role of traditional practitioners in promoting health": A Case study of Pfura Rural District Council (registered practitioners). The data will be collected through in-depth interviews wherein the recorded data will be kept confidential. Attached to this letter is the consent form, ethical clearance certificate, national identity copy and copy of a student card.

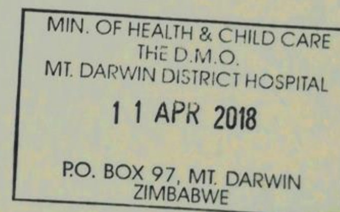
I am therefore kindly requesting for your permission to conduct in-depth interviews with the registered traditional health practitioners in your area. I am of the hope that the findings of this study will, assist us in sustaining the traditional practices for the benefits of the present and future generation.

Your cooperation and assistance is highly appreciated for the success of this study.

Yours Faithfully

Pfungwa Mambanga





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Appendix H: Sample Transcript of the interview

Interview transcript #08#

Date: 18 April 2018.

Place: Village A of Ward X in Mt Darwin District Council, Mash-Central Zimbabwe.

It is a culture of Kore-kore people that if you want to talk to elders you ask for permission first. On the 17th of April 2018, I went to the house of the 8th respondent whom I was referred to by the earlier participant. She was a diviner and herbalist's practitioner. I introduced myself and my totem which is an important aspect in introductions of Shona people and I explained to her about my visit, outlined the purpose of then interview in order to get her consent. She told me that she was not free that day since she was to attend a civic meeting, then she told me that I should come on the 18th. She told me that if am coming the following day I should also notify the village head about my visit. To her time was very important as she emphasized that she also wanted to attend the Zimbabwean independence celebration on the same day.

So I had to work up early so I can interview her at 7 o'clock in the morning. On the day of the interview she cautioned me that they were certain things that I should adhere to, the first was that if she was to take me to here consultation room, I was supposed to see and taking notes only, any electronic device wasn't allowed, saying that the spirit was not the each so, it will be disrespectful to bring audio devices including a phone. When I visited this traditional practitioner I was also told that if he enters his consultation room, I was nt going to interrupt her nation, therefore the question should be asked fist and then she can narrate the answer agreed to her rules and we firstly did an interview outside the consultation room then later we moved.

Section A: Traditional Health Practitioners Profile

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Gender: **Female**

Age**; Born 1926 (92 years)**

Village: **A**

Level of education: **Did not attend school**

Type of Traditional Practice; **N'anga (diviner, herbalists)**

Source of power/knowledge: **Shave renjuzu/mermaid spirit**

Number of years in practice: **50 Years**

Number of patients served: **5-10 patients**

Description of sphere of influence: **Patients from town and rural areas**

Sectional B (CENTRAL QUESTION): **THE ROLE OF THE TRADITIONAL HEALTH PRACTIONERS IN PROMOTING HEALTH.**

- What are the indigenous health promotion practices in Pfura Rural District?
- What are the challenges facing traditional health practitioners?
- What are the strategies to enhance and sustain traditional health promotion practices in a rural setting?

KEY: PM-Pfungwa Mambanga (Interviewer)

#08#-Respondent

PM	How are you Mbuya(grandmother)
08	I am good and you?

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PM	I am very fine, I have visited you today
08	That is good to see you here, where do you come from
PM	My name is Pfungwa Mambanga of the Mhofu yemukono trotem, I live in Majabvu village under headman Paul Makenzi of the Nzou Smanyanga tortem. I came yesterday telling you that I am a student from University in South Africa(interrupted)
08	Hooo I remember you now, I remember your voice we spoke yesterday, you see some times my sight is not good, don't mind. That's is very good, with your toterm meaning you my inlaw because my late brother married a women from the Mhofu torten, down there in Pfunyanguwo (she laughed)
pm	Ok that's good (smiling)
08	Yaa feel free here it is your home,(with a louder voice filled with joy) Gamu please bring drinking water and maheu for my young in-law here.
pm	(Clapping hands as a sign of appreciation) no problem Mbuya , thank you for the offer, but was thinking if we do the interview then we can eat after.
08	(laughing) you am older I almost forgotten that you come here to teach me today , age is killing me, do you know my age mate is Mugabe (we all laughed)
pm	Today its you teaching me about your work as a traditional healer
08	Its okay, lets go forward
pm	May you explain to me your practice name, your age and the year your started practicing
08	I was born in 1926 in the rural area of Kapfudza in Dande valley, my name is Kabiri Egenesi, but my practice nickname name is Mbuya Mukwatura (to slap someone with a hand). I started traditional healing from a tender age of 9.
pm	That's great you have been working for a long time, if I may ask before we look at your duties in promoting health, How did you get the nickname Mbuya Mukwatura.
08	Young boys like you are the ones who gave me that name, after I gave them herbs for different diseases such as STD/*Njovera* and other come to get the once

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	for sexual endurance, charms for women (she laughed) , so they will come back and say , the herbs worked very well.
pm	Okay that good meaning you herbs are good hey! Taking you back a little bit, as traditional healer I suspect they are powers in your which guide you knowledge and skills of healing, may kindly tell me about the source of your herbal knowledge and healing skills
08	Like I have showed that I started healing people at a tender age, I have a spirit of a mermaid/njuzu. This spirit it came to me at an age of 8, my parents repotted that i disappeared when we went to nearby pool which was a sacred pool, but you as kids you sometime became naught and you want to go were you are not allowed. Was told that I disappeared for 6 months. I remember were I was but not knowing how got there. It was a different worked living with snakes and finish, it felt and looked like a life under water. So when I come back I found my self at a poor side and I saw the whole village waiting , beating drums , and drinking beer, in celebrating that I was back.
pm	It sounds very sad for you as you as you were, so by the time when you come how was your feeling and how did this relate to your healing practice.
08	Life in the underwater world was all about herbs and dreams, so when I was back I started to dream about herbs and how to process them, and it health people.
pm	So Mbuya Mukwatura what type of conditions do deal with from day in day out, and how is de frequency of patients.
08	All the disease I can cure my son, what I can't do is resurrecting a dead person only
pm	(we all laughed) you can go ahead Mbuya narrating more on healing
08	Okay myself I diagnose in many ways. For example, you come here with your wife and you are complaining about not having (infertility) a child for so long, I then go into history by asking you question about your sex life, all other visible aspects we can talk of, does your wife menstruate and for how, what time of the

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	month do you normally mate. All these questions they will assist me to identify where exactly will be the problem before I decide on which herb to give them.
pm	So, you mean when you want to cure you diagnose through the spirit and by physical assessment of patients?
08	Yes, like in some disease like STIs and cancer for example the signs and symptoms a public secret although in some cases they manifest differently, in that way I do take my time before giving any herb. Apart from what the patient says I also have patients who have been trying the medical doctors for long times with no change,
pm	How do you know that they are from the medical doctors?
08	Some can show your there medical cards, I can't read but I cant just believe them, some are also referred by doctors themselves , because the doctors some of them knows me as traditional healer , so they refer. So in that regard will not need to see any card.
pm	This is great work for the community so apart from the sick people , I recall you once mentioned earlier on about young boys who usually visit you for herbs
08	I will request them to bring the card so that I can see and read before assisting them. On the other side I have people who are health physically so , but they want clean and boost their immune e system (detoxication/*kugeza muviri*), I do have what I call Guchu that means it is a mixture of several herbs which are mixed in water, I then give patience that water to drink. The Guchu clears the body and renews it in no time and the immune system is boosted. If you want a bottle I will give you for free you are now my friend (she laughed). So in other words I can say I deal with all types of patients like who are sick, consulting for prevention and some times since we are under Mt Darwin Hospital ,nurses sometimes refer patients especially cancer/mhuka patients to us. In all this I only assist patients who come early when their condition are still manageable not a

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	critical stage, me am just a herbalist without life supporting machines, so I refer them to hospitals
pm	Before I forgot, in your introduction you spoke about sacred pools where you got disappeared, kindly explain more about these sacred places in your practices
08	Scared places are dying due to modernization together with taboos of our tribe, the English life that white people brought here.
pm	What are these taboos?
08	Taboos are does and don’ts of our land which govern how we should conducted our service either in health wise or environmental
pm	Okay, so these taboos are there still having place in Pfura?
08	Yes, I can testify that you have been doing a great job for quite some time, Do you know where the air you breathe does comes from? Our life comes from the environment and from our vadzimu (ancestors) and these two you can’t joke with them, they will disappear or they get angry and we can be struck by a curse. Here we do have Zingore River we don’t allow people to bath there or even wash dishes, in an even you want bath you don’t use soap or any detergent, if you do that you easily disappear forever. Madzvinzvi the mountain you see when you were coming here they are many fruits indigenous which have extinct in many areas, our ancestors here told us that we eat what we can finish, if you take them home you disappear or you risk a family member to die. The Makombe people are not allowed to do sex before marriage, your mother will develop hernia. Taboos are not evil my son, because the scripture even supports our taboo that says a woman after birth she will abstain from sex for three months and she is not allowed to prepare food and other household chores. There is a belief that if she does sex for that period the husband will become sick. My own opinion on the health promotion effect of this is that, during childbirth a mother suffers a pain form bleeding and some mothers can suffer depression and pelvic pain just

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	mention a few, so it will be wise to give her enough time to heal before engaging in sexual activities"
pm	How you ensure that these taboos are followed?
08	When our kids are growing up from theier homes are being taugh these laws of our land.
pm	Do you see these practices of taboos going far in as much as the protection of our health culture is concerned.
08	Yaa a little far. Much is needed to be done in dealing will teaching and mentoring our kids and the young generation to uphold these Kore-kore beliefs, if they uphold the spirits of the land will keep on keeping us safe from danger
pm	What are these spirits of the land which you are always mentioneing
08	When you were growing up I guess you have heard of the word Mhondoro (spirit of a lion), mhondoro is the spirit that govern the land of Kore Kore people. All these other diviners and herbalists are ordained by Mhondoro practice after verification of checking if really the spirit is to honestly to protect our clan or not. We do the regulation because we have noticed fake n'anga in neighboring lands where they are performing mashiripiti (magic) and get away with cattle from our people. It only the responsible of Mhondoro to ensure that Zviera era (taboos) are respected and obeyed by the current generation.
pm	So what is the role of these Mhondoro in terms of health promotion of the land
08	Before I forgot, remember I told you that the spirit in me oversees and protects this land, in 1958 the spirit told the people that chipembwe (whooping cough) is coming, and the whole clan we performed rituals and during the ritual all the young people were given herbal mixtures to prevent them and when it struck the land we were served and not even a single death was reported as compared to our counterparts. Although I sometimes but in rare occasions I can be a herbalists, I only diagnose with the spirit within me. Recently we had persisting drought and people had hunger, and you know hunger is not good for our health,

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	it comes with many diseases especially to infants, 2016 here I led a rain making ceremony and 2017 it was a good season for us with plenty to eat for us and our animals.
pm	This is great of so Mbuya Mukwatura you have been assisting this land for a long time, may you kindly elaborate further on the party of you administering herbs to patients before you say something about challenges and your views for better health promotion
	what I cannot do is operation/surgery of anything in your stomach. My history says it all, I healed a boy in 1965 who was bitten by a snake two days back, at a stage when he could not do anything but to die, the spirit in me sense me to the forest and fetch the herb that served the boy.
pm	How did you manage such an emergency?
08	Its not only that snake bite that I boost my self of, I have many patients who survived a cataract because of me, for cataract I just apply powder I make in your eye after two hours you will give me the answer
pm	As a good practitioner, personally how are you failing to manage you own sight problem
08	*Vakuru vakati nyoka huru haizvirume* (a big snake cannot bite itself) it means a traditional healer cannot cure him/herself that you see me blind. If it was not because of my grandson, who love my work, most people could have died, he is now helping me in herbalism since he got his vision unlike me. Lack of appeasing ceremonies and other traditional ceremonies is making chivanhu (IKS) a blow. Let people respect the ancestors through ceremonies, it will make the cultural fabric that binds us with our roots strong. I blame colonization for all this, as you can see that the seed of colonization has manifested in plant called Christianity

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	which many uses as a weapon destabilizing IKS which we have and we stay surviving with (showing a very sad and angry face). Lets go back to our roots and reclaim the African pride then we can conquer these mush rooming diseases.
pm	You have touched some aspect of challenges and possible solution , what more can share with me from your experiences
08	There is no more emphasis to revive chivanhu/IKS starting from appreciating out African forefather and traditional leader (Madzimabo/Chiefs & Kings) to be given platforms to come with solutions. We can go in my consultation room, just for you to see an d tell your friends to come and built me a nice room (she laughed as she was leading the way to the a small room)
pm	You room is rich with herbs I see
08	I want to come and leaner how to use herbs(laughing), you should buy me my cultural clothers, look at these one (point at a busket with cultural attire which was visibly tone)
pm	That was resounding recommendation from you and I would want to thank you once again for you time and contribution to my study thank you. .
08	I have given you numbers of my grandson , call them and talk to them, we will meet one day I would like to read about this interview, that my wish that let records be kept, because oral tradition distort the meaning of history. Thank you

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