THE PERCEPTIONS OF AFRICAN TRADITIONAL HEALERS AND BIOMEDICAL PRACTITIONERS TOWARDS *AMAFUFUNYANA*: HEALING, PREVENTION AND POSSIBILITIES OF MUTUAL COLLABORATION IN HLABISA (KWAZULU-NATAL)

by

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Declaration

In terms of Rule G9.8 of the Wits University Humanities Rules and Syllabus (2022), I, Simangele Senamile Sithole, declare that this research report is my own, unaided work. I submit it for the Degree of Master of Arts (Sociology) at the University of the Witwatersrand, Johannesburg. I have not submitted it before for any degree or examination at any other university.

Signed  on this **8th** day of **April 2022** at Port Shepstone.

Abstract

In South Africa, *amafufunyana* is a condition that is perceived differently across cultural settings. Its conceptualisation differs from time to time and remains contested. From a biomedical perspective, it is seen as a type of mental disorder, while from a traditional healing perspective, it is viewed as a type of spiritual possession that mimics mental disturbance. A qualitative research approach was implemented to guide this study which aimed to explore the perceptions of African traditional healers and biomedical practitioners on *amafufunyana* by focusing on healing, prevention, and the possibilities of mutual collaboration. Through snowball sampling, five psychiatric nurses, a neuropsychologist and five traditional healers were interviewed telephonically to collect data. Thematic analysis was used as means of analysing data. The findings from this study suggest that the contestation surrounding the condition of *amafufunyana* emanate from a lack of both medical integration and medical collaboration in healthcare. Context determines the understanding of the different interpretations of *amafufunyana* by biomedical practitioners and traditional healers and informs their different techniques of healing and prevention. Additionally, both traditional healers and biomedical practitioners indicated their willingness to work together on a conditional basis. By using *amafufunyana* as an example, this study revisits the challenges to medical integration and suggests the idea of parallel cooperation as an alternative.

Keywords: *Amafufunyana*, mental illness, spirit possession, prevention, collaboration, medical integration, parallel cooperation

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CHAPTER ONE

INTRODUCTION AND RESEARCH PROBLEM

1.1 Introduction

This study explores the perceptions of African traditional healers[1] and biomedical practitioners[2] on *amafufunyana* by focusing on its healing and prevention and the possibilities of mutual collaboration in Hlabisa (KwaZulu-Natal). Based on the findings of this study, the thesis statement is that parallel cooperation[3] should be considered as a way of bridging the cultural gaps between biomedical practitioners and traditional healers.

The study's thesis statement is extended from Maqalika's (2020) argument that suggests that collaboration between indigenous practitioners and mental health practitioners requires medical integration[4]. However, Maqalika's stance differs from this study because her argument did not explicitly state how indigenous practitioners and mental health practitioners could collaborate. This study's argument contends that parallel cooperation should be considered as a way of bridging the cultural gaps between biomedical practitioners and traditional healers in their management of the condition of *amafufunyana*. The idea of parallel cooperation applied in this study was derived from Bodeker (2001).

According to Patel, Minas, Cohen, and Prince (2013) culture shapes how illness is experienced by all persons affected, thus influencing how it is communicated to others and presented in clinical settings (Ikwuka, 2021). This is supported by Booysen, Mahe-Poyo, and Grant (2021) in their study that stated culture is an aspect is significant in conceptualising patients' experiences of mental disorders/illness.

African traditional healers, biomedical practitioners and patients have different understandings and interpretations of illness (Seidlein & Salloch, 2019). For example,

[1] It refers to the sample of Faith healers and herbalists as explained in Chapter Three.
[2] It refers to the sample of Psychiatric nurses and neuropsychologists as explained in Chapter Three.
[3] Parallel cooperation is a type of medical collaboration which is lent from Boon, Verhoef, O'Hara, and Findlay (2004); Mostaghim & Schmeck (2009) believe that parallel cooperation exists when healthcare practitioners work independently of one another in a common practice by negotiating about which cases on which to work.
[4] The concept of medical integration is critically discussed in Chapter Two and Chapter Five.

a study by Tsao et al. (2021) on perceptions of COVID-19 showed how social media influenced public attitude towards tackling the issue of inaccurate information on COVID-19. Their key findings determined that each social media platform had different definitions of COVID-19 and its vaccinations (Tsao, et al., 2021). This is an indication that interpretations of illness are understood differently even in a global context.

Similarly, while *amafufunyana* features among Southern Nguni people, the condition is understood and interpreted differently between and within the Zulu and Xhosa cultures (Train et al., 2007). Additionally, Van de Watt, Das-Brailsford, Mbanga, and Seedat (2020) state that *amafufunyana* is a concept that is commonly used by traditional healers in describing mental health issues. Sibisi (1975) explains that *amafufunyana* is a spirit possession caused by evil spirits which cause mental instability.

The inconsistencies of this condition have influenced academic scholars in their debate to determine whether *amafufunyana* is a concept widely used when referring to emotional distress, mental illness/disorders or spirit possession (Campbell, Sibeko & Mall, 2017; Ensink & Robertson, 1996; Lund & Swartz, 1998; Mzimkulu & Simbayi, 2006; Niehaus et al., 2004; Sibisi, 1975; Van de Watt et al., 2020). The historical context of *amafufunyana* centres around issues of mental instabilities and abnormal behaviour which seems to explain a complex set of symptoms as discussed in Chapter Two and Chapter Four. For example, Train (2007) and Van de Watt et.al (2020) reports that symptoms of disorders differs across cultures even when the same disorders are found in a similar cultural group, it seems that symptoms are contextualised within that certain culture.

This chapter consists of the following nine sub-sections: the background of the study, the research problem, the statement of the problem, the rationale of the study, research questions, research objectives, the aim of the study, the significance of the study and the organisation of the research report.

1.2 Background of the study

This section highlights the challenges posed by the conceptualisation of *amafufunyana* and *eemwengu*. A brief overview of how cultural beliefs are embedded in conceptualising *amafufunyana* and *eemwengu* is given and the history of healthcare

systems in a South African context is provided to create a clear understanding. The existing healthcare system and its infrastructure are overstrained and mental healthcare[5] services are scarce in Southern Africa; sometimes, mental illness is not well understood (Bartholomew, 2018; Booysen et al., 2021; Maphumulo & Bhengu, 2019; Mokgobi, 2014).

Booysen et al. (2021) indicate that mental disorders are ignored in non-Western cultures because the nature of psychology as a theory and practice is underfunded and, thus, the practice is unfamiliar (Bartholomew, 2018). This, of course, has implications for the accessibility of mental healthcare (Bartholomew, 2018).

In some areas, mental health services may be available but they do not normally align with the cultural beliefs of patients. For instance, among the Namibian Aawambo, the culturally identified condition of *eemwengu* – said to resemble 'madness' – exists (Bartholomew, 2018). The concept is used to identify the symptoms of an abnormal mental state believed to be caused by witchcraft. According to Bartholomew (2018), this condition is used to 'other' certain individuals who are classified as 'abnormal'. The link between *eemwengu* and *amafufunyana* are on the basis that both conditions are cultural identified which exhibits complex descriptions of symptoms which can locate and identify mental illness.

The conceptualisation of *eemwengu* is similar to that of *amafufunyana* because literature demonstrates how cultural beliefs are embedded in conceptualising abnormal behaviour which might be linked to mental illness (Bartholomew, 2018). These cultural conceptualised conditions are normally viewed in one of two ways: either as variations of similar psychiatric disorders that are seen in a Western context or as disorders that are unique to the cultures from which they originate (Coetzer & Balchin, 2014). In this study, both such interpretations regarding *amafufunyana* were revealed by the traditional healers and biomedical practitioners.

Increasing debates about *amafufunyana* as a 'culture-bound' condition occur; the condition is believed to have originated in the Xhosa and Zulu cultures (Helman, 2007; Train et al., 2007) and is sometimes described as variations of mental disorders or

[5] According to Bartholomew (2018), mental healthcare is a clinical service offered by psychologists, psychiatrists, counsellors and social workers.

emotional distress (Swartz, 2010). Such debates often present within a cultural context that may be misinterpreted.

In both classical and recent anthropological literature, this condition is considered to be fully explained by a system of meanings gleaned from where it is likely to be prevalent (Helman, 2007; Ngqila, 2015). For example, *amafufunyana* is attributed to witchcraft which results in spirit possession (Edwards, 1984; Sibisi, 1975; Train et al., 2007). This is very different from psychiatric literature which considers *amafufunyana* as a concept used by patients and traditional healers to explain symptoms of psychosis or schizophrenia (Campbell et al., 2017; Niehaus et al., 2004; Swartz, 2010).

According to Keikelame and Swartz (2015), a study on traditional healer perspectives on epilepsy highlighted *amafufunyana* as one of the causes of epilepsy. However, the study lacks analytical literature on how *amafufunyana* can be prevented by biomedical practitioners and traditional healers. Their study views traditional healing as having harmed patients; biomedical practitioners would not approve of traditional healing treatments since they are not medically tested (Keikelame & Swartz, 2015).

In medical integration, there is an expectation that African traditional practitioners have to learn from biomedical practitioners and familiarise with biomedical concepts towards their practice and refer patients with serious cases to the biomedical health sector for them to be seen as equal counterparts (Campbell-Hall, et al., 2010; Cassim, 2014; Wreford, 2005). Traditional healing systems are thus side-lined in mainstream healthcare (Mokgobi, 2014). Medical integration seeks to emphasise the combination of conventional and alternative medicine in addressing the biological, social, spiritual, and psychological aspects of health and illness (Rakel, 2007).

Furthermore, biomedical practitioners and African traditional healers have a history of having to work in isolation. African traditional healers offer an alternative system of healing; they claim a holistic treatment of illnesses (Bartholomew, 2018; Campbell-Hall, et al., 2010). The allopathic service providers form part of public and private health care systems (Campbell et al., 2017). Before South Africa was a democratic state, African traditional healers were forbidden from practising as healthcare workers – the result of the Health Professions Act 56 of 1974 (Mokgobi, 2013). This Act

permitted only registered healthcare workers to practice medicine (Mothibe & Sibanda, 2019).

Despite this legislation, the Traditional Health Practitioners Act 22 of 2007 was passed to formally recognise traditional healers and their practice within various communities (South Africa, 2008). After nine years of democracy, the Department of Health (DoH) declared that traditional healers could practice as healthcare practitioners in South Africa (South Africa, 2008). However, traditional healers are still not supported by the government and their contribution towards mental conditions remains unacknowledged (Campbell-Hall, et al., 2010; Sehoana, 2015).

In this study, the findings revealed that African traditional healers believe *amafufunyana* is a spiritually rooted illness that results from witchcraft and, therefore, can only be treated through a series of rituals and medicinal herbs. Biomedical practitioners, on the other hand, use this broad term to explain mental illnesses such as hysteria, schizophrenia and psychosis and seek to treat them by a combination of psychotherapy and anti-psychotic medications.

For this reason, the study's thesis statement is that parallel cooperation should be considered as a way of integrating the practices of biomedical practitioners and traditional healers. This is demonstrated in the chapters to follow and guided by a qualitative research approach. The findings of this study represent neither the entire population of KwaZulu-Natal nor South Africa but could be used as a foundation to investigate and explore the different perspectives on *amafufunyana* across South Africa more extensively.

1.3 Research problem

No common ground regarding how each healing system conceptualises illness exists (Booysen et al., 2021; Mokgobi, 2014). This contestation widens the existing knowledge and treatment gaps between traditional healers and biomedical practitioners because their approaches to healing are informed by their understanding of illness. For instance, traditional healers perceive *amafufunyana* as spirit possession, while biomedical practitioners perceive it as a variety of mental disorders (Campbell et al., 2017; Ensink & Robertson, 1996; Lund & Swartz, 1998; Mzimkulu & Simbayi, 2006; Niehaus et al., 2004; Sibisi, 1975; Van de Watt et al., 2020). Due to this

knowledge gap, the literature often emphasises medical integration (Bartholomew, 2015; Campbell-Hall et al., 2010; Maqalika, 2020).

In promoting an integrative approach, ideally, collaboration between traditional healers and biomedical practitioners must be achieved (Boon, Mior, Barnsley, Ashbury, & Haig, 2009; Dawda, 2019). However, in the context of South Africa, medical integration has not worked (Mokgobi, 2013). The underlying issue is that medical integration is misunderstood and unsustainable in short-term collaborative projects (Campbell-Hall et al., 2010; Hlabano, 2013; Maphumulo & Bhengu, 2019). To confirm the previous point, Mokgobi (2014) mentions that an integrative approach is complex and short-lived in the South African context. Therefore, this study revisits the challenges to medical integration by using *amafufunyana* as an example and suggests the idea of parallel cooperation as an alternative.

1.4 Statement of the problem

The South African healthcare system has been overwhelmed for decades and even after efforts were made to strengthen its performance (Malakoane, Heunis, Chikobvu, Kigozi, & Kruger, 2020). The lack of medical integration is due to the existing constraints on finance, infrastructure and poor policy implementation that have led to a more fragmented system (Malakoane et al., 2020). As part of the 2030 Health Millennium Development Goals, the World Health Organisation (WHO) (2008) has provided guidelines on how African traditional healing and other non-conventional healing systems could be integrated into mainstream healthcare (Mutola, Pemunta, & Ngo, 2021).

Despite this, in the context of South African context, medical integration appears to be ineffective. For medical integration to be successful, Mutola et al. (2021) suggest that the government must provide regulatory provisions for traditional healers and show their political will in this process. The relationship between biomedical practitioners and traditional healers has been parallel. The shift to an integrated system needs cooperation from both healing systems (Banfield, Jowsey, Parkinson, Douglas, & Dawda, 2017). Access to healthcare must be more community-centred than hospital-centred (Mutola et al., 2021).

The challenge is that a "one size fits all" approach to integration is not feasible because the nature of healthcare is complex (Campbell-Hall et al., 2010, p. 624; Dawda, 2019, p. 2). The difficulty to apply and measure integration from one setting to another because of historical and geographical contexts seems to cause this issue (Banfield et al., 2017).

The debate on what should constitute the definition of mental illnesses/disorders is still ongoing (Canino & Alegría, 2008; Palumbo & Galderisi, 2020; Train et al., 2007). Due to this, definitions of illnesses, such as *amafufunyana*, are context-dependent (Palumbo & Galderisi, 2020). Boeree (2006) maintains that definitions of mental disorders are never complete because of how they differ and are perceived from culture to culture and across different regions. In contrast, the pancultural approach takes a stance in abnormal psychology and argues that the same mental illnesses exist in all cultures. However, academic scholars propose a criterion regarding factors – said to be biomedically and culturally determined – that should be included when trying to conceptualise mental illness (Palumbo & Galderisi, 2020).

The proposition of the pancultural approach is problematic because of how symptoms and mental disorders are expressed differently within cultural contexts (Sehoana, 2015; Train et al., 2007). The case of *amafufunyana* is an example; the condition is understood and interpreted differently by African traditional healers and biomedical practitioners (Campbell et al., 2017; Niehaus et al., 2004). One can therefore conclude that it has no universal definition which can be applied across different contexts.

This study focused on the seemingly under-researched condition of *amafufunyana* (Sehoana, 2015) to explore the perceptions surrounding *amafufunyana* in terms of healing and prevention and the possibilities of mutual collaboration between biomedical practitioners and African traditional healers in a South African context. Along with the existing literature and findings, this study will argue that parallel cooperation should be considered as a way of bridging the cultural gaps between biomedical practitioners and traditional healers.

1.5 Rationale of the study

A previous study on *amafufunyana* focused on categories of distress among Xhosa-speaking traditional healers (Ensink & Robertson, 1996); another study looked at the

schizophrenic patient's experience in terms of the concept of *amafufunyana* and promoted placing *amafufunyana* within psychiatric evaluations (Niehaus et al., 2004). Sibisi's (1975) study shed light on traditional healers' conceptualisation of *amafufunyana* as spirit possession in KwaZulu-Natal.

These three studies all shared common features; they focused on the causes and treatment of *amafufunyana* but did not address perceptions of prevention and collaboration (Ensink & Robertson, 1996; Niehaus et al., 2004; Sibisi, 1975). One can deduce that *amafufunyana* is a broad concept across the Southern Nguni cultures and has different definitions and interpretations. These differences motivated the researcher to conduct this study among the African traditional healers and biomedical practitioners in Hlabisa, thus, placing the study within the Zulu culture.

The existing gaps in the debate on medical integration and mutual collaboration on the condition of *amafufunyana* have also motivated the researcher to conduct this study and a relational perspective has been applied to guide the research process. This study investigates factors such as causes, methods of healing, prevention and the possibilities of collaboration between African traditional healers and biomedical practitioners. This study offers proposals to quell the debates on medical integration by suggesting parallel cooperation on *amafufunyana* as the most viable proposition.

1.6 Research question

The primary research question is the following:

1. What are the perceptions of African traditional healers and biomedical practitioners on healing and prevention and the possibilities of mutual collaboration on *amafufunyana* in Hlabisa, KwaZulu-Natal?

Sub-questions assist in answering the main question (Ratan, Anand, & Ratan, 2019). The following sub-questions were formulated:

2. How do African traditional healers and biomedical practitioners understand *amafufunyana*?
3. In what ways is the condition of *amafufunyana* treated?

4. How can African traditional healers and biomedical practitioners identify ways of collaboration in the treatment of *amafufunyana*?

1.7 Research objectives

Research objectives are statements of intent that describe what the researcher will be doing during fieldwork (Tomcho, Rice, Foels, & Folmsbee, 2009). The objectives of this study are as follows:

1. To describe how biomedical practitioners and African traditional healers interpret the condition of *amafufunyana*.
2. To explore how African traditional healers and biomedical practitioners explain the causes of *amafufunyana*.
3. To compare the methods used by biomedical practitioners and African traditional healers to prevent *amafufunyana*.
4. To compare if African traditional healers and biomedical practitioners have an interest in collaborating on the treatment of *amafufunyana*.

1.8 Aim of the study

The aim of a study is the statement of the purpose that the research hopes to achieve after fieldwork has been completed (Thomas & Hodges, 2010). This study argues for parallel cooperation between traditional healers and biomedical practitioners. In so doing, it shifts away from arguments for medical integration and mutual cooperation and suggests parallel cooperation on the condition of *amafufunyana* in a South African context. Chapter Five of this study explains how the aim of achieving parallel cooperation was achieved by demonstrating that different health conditions cannot necessarily be resolved by mutual cooperation. Cooperation is needed between the two healing systems but is dependent on the nature of the condition – *amafufunyana* in the case of this study.

1.9 Significance of the study

As healthcare is inadequate, the implications of the limitations on how illness and health-seeking behaviour is understood and misunderstood are significant (Booysen et al., 2021; Mokgobi, 2013). Early studies of *amafufunyana* have described it as a

type of spirit possession or hysteria (Ensink & Robertson, 1996; Lund & Swartz, 1998; Niehaus et al., 2004; Sibisi, 1975). This study demonstrates how biomedical practitioners and African traditional healers perceive *amafufunyana*. Therefore, the implications of the study's findings will contribute to the debates on medical integration amid the contextual complexities of *amafufunyana*.

1.10 Organisation of the research report

Chapter One located the study within relevant literature and by so doing revealed the knowledge gaps in medical integration, prevention and collaboration on *amafufunyana* in previous studies. The research questions stemmed from the identified gaps. Chapter Two critically discusses the perceptions of *amafufunyana* and reveals the debates regarding medical pluralism and the possibilities of medical integration and collaboration.

The third chapter discussed research methodology. A qualitative research method and research design are implemented to answer the research question: What are the perceptions of African traditional healers and biomedical practitioners on healing and preventing and the possibilities of mutual collaboration on *amafufunyana* in Hlabisa, KwaZulu-Natal? The snowballing technique was used to select potential participants, the research instruments (telephonic interviews) employed for data collection and thematic data analysis that was implemented will be outlined.

The fourth chapter focuses on the findings of the study which are based on the themes that emerged from the data analysis: mental illness, various causes, psychotherapy and anti-psychotics, supportive awareness campaigns, parallel collaboration, evil spiritual possession, witchcraft, 'ukushunqiselwa' and prayer, 'ukuqiniswa' ritual and partnership.

Chapter Five uses the study's findings and the literature to argue that parallel cooperation should be considered as a way to bridge the cultural gaps between biomedical practitioners and traditional healers. Finally, Chapter Six concludes the report and provides recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a literature review that focuses on the evolving interpretations of *amafufunyana*. After having identified gaps in the literature regarding the least explored factors of the prevention and collaboration in the treatment of *amafufunyana*, these factors need to be integrated into the literature. The additional gap identified is that often narratives are one-sided and either focus on patients' experiences or those of traditional healers. Therefore, this chapter looks at the different perspectives on *amafufunyana* and discusses the possibilities of collaboration, medical integration and medical pluralism.

The factors surrounding the possibilities of collaboration will be illustrated through an analysis of previous research in the areas of tuberculosis (TB), the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). This chapter will highlight that collaboration between traditional healers and biomedical practitioners regarding the treatment of mental illness/disorders has not yet taken place (Van de Watt et al., 2020).

This chapter is sub-divided into four sections: the perceptions of *amafufunyana*, possibilities of collaboration, medical pluralism and medical integration. These sections link intrinsically to the research question: What are the perceptions of African traditional healers and biomedical practitioners on healing and prevention and the possibilities of mutual collaboration on *amafufunyana* in Hlabisa, KwaZulu-Natal.

2.2 Perceptions of *amafufunyana*

In South African traditional healing systems, *amafufunyana* is one of three types of spirit possession (Sibisi, 1975). The first type involves the ancestral spirit which is known as 'ukuthwasa'. The second type is evil spirit possession which is known as *amafufunyana*. The last type is alien spirit possession which is known as 'indiki'.

The ancestral spirit is the spirit that is induced by ancestors as a call to become one with the divine (Sibisi, 1975). Unlike *amafufunyana* which requires treatment, the process of 'ukuthwasa' is considered a positive spiritual possession and a rite of

passage for an individual who is believed to possess this ancestral spirit and seeks to become a traditional healer (Sibisi, 1975). Dreams are believed to be the primary medium through which ancestors communicate and pass the knowledge of healing to healers (Ember & Ember, 2003). Therefore, dreams serve as a link between humans and their ancestors.

As mentioned, from an African cultural point of view ukuthwasa is an "emotional turmoil" which forms part and parcel towards initiating someone into becoming a traditional healer (Helman, 2007). The descriptions of ukuthwasa differs across the Nguni cultures which is commonly characterised by social withdrawal, wild dreams and fears of madness (Helman, 2007). Whilst it has been reported that ukuthwasa is not a form of psychosis but rather a calling which typically includes hallucinations and abnormal behaviour (Swartz, 2010). Ukuthwasa differs from *amafufunyana* because it needs one to appease the ancestors whilst in *amafufunyana* one needs to seek for treatment.

However, both *amafufunyana* and 'ukuthwasa' have been perceived in Western psychiatry to be a form of psychosis or a culture-bound syndrome (Lund & Swartz, 1998; Mdleleni, 1990; Niehaus et al., 2004). With these complexities in mind, such conditions are normally viewed in one of two ways: either as variations of similar psychiatric disorders seen in a Western context or as disorders that are unique to the cultures from which they originate (Coetzer & Balchin, 2014).

2.2.1 African cultural interpretations

Sibisi (1975) and Ngubane (1977), anthropologists who conducted ethnographic research on the people of KwaNyuswa in KwaZulu-Natal, described *amafufunyana* or 'izizwe' possession as a form of spirit possession that is caused by witchcraft and sorcery. The traditional healers in this study hold a similar belief and see *amafufunyana* as indeed an evil spirit possession that is primarily caused by witchcraft and assumed to be centred on hatred and jealousy towards the afflicted person.

This indicates that traditional healers use the same explanatory models of illness and disease even though they are a heterogeneous group. However, in this study, the findings revealed that 'izizwe' is a type of medicinal plant that is used to attract evil spirits as opposed to 'izizwe' being a type of spirit possession. Sibisi's (1975, p. 56)

interpretation of *amafufunyana* might be linked to 'psychogenic illness' – a medical condition which is believed to be caused by emotional stressors. Psychogenic illness refers to a biomarker that has not yet been identified (Sibisi, 1975).

Ngubane (1977) mentioned that, among 'ethno-doctors', *amafufunyana* is a condition of being spiritually possessed and afflicts mainly people (especially females) who are in a powerless economic and social position. As such, it helps to draw attention to their suffering and to mobilise a caring network around them. Treatment is likely to occur in the form of a ritual whereby a traditional healer replaces the 'alien spirits' with 'ancestor spirits' (exorcism) (Helman, 2007; Sibisi, 1975). Sibisi (1975) further points out that symbolic treatments are used when treating spirit possession; for example, black and red medicines are used for bad and severe symptoms of *amafufunyana*. The use of white medicines occurs afterwards in the belief that his/her good spirits will be retained.

In this study, traditional healers linked the concept of ancestors in their definitions and treatments of *amafufunyana*. Traditional healers explain how the evil spirit camouflages itself as an ancestral spirit to control the possessed and the possessed will likely cry hysterically, becomes violent, being anti-social and runs away as if they are being chased by someone. Sibisi (1975) identified similar clinical indications.

Furthermore, from an African traditional perspective, the protocols for treating *amafufunyana* seem to differ. In this study, treating *amafufunyana* varied because traditional healers are not a homogenous group. For example, faith healers (umthandazi) use prayer, 'isiwasho' (holy water) and 'imphepho'; herbalists (isangoma) use a variety of medicinal plants, 'ukushunqisela' (smoke inhalation) and 'ukuphalaza' (induced vomiting).

Another type of ritual mentioned by the traditional healers in this study was 'ukuqiniswa' – a preventative measure to repel the evil spirit. This ritual – wearing red ropes around one's waist and making bodily joint incisions – is believed to protect and strengthen the subject against evil spirits. The ritual is said to be the traditional equivalent of vaccination in spiritual illnesses (Baxter & Low, 2017). However, Baxter & Low's (2017) study was not specific on whether the ritual could be used in the case of *amafufunyana* or was just a generic for spirit possessions.

2.2.2 Biomedical interpretations

The study of Niehaus et al. (2004) suggests that *amafufunyana* was initially labelled as "an agitated condition characterised by people speaking in an unusual language that cannot be understood" (Niehaus et al., 2004, p. 60). Van de Watt et al. (2020) maintain that the concept is commonly used by traditional healers to describe cases of emotional distress and psychological health issues. The symptoms comprise ferocious behaviour, tearing off clothes and some sort of anxiety (Niehaus et al., 2004).

Niehaus et al. (2004) concluded that patients might be using the concept of *amafufunyana* when presenting with the symptoms of schizophrenia because the concept has a spiritual dimension. From a biomedical framework, schizophrenia is identified as a psychotic disorder in which "an insidious but progressive development of oddities of conduct, inability to meet the demands of the society, and decline in total performance" occur (Durbano, 2018, p. 49). This suggests that a person who is schizophrenic loses sense of reality and that the disorder is normally classified under psychotic behaviour.

Similarly, Mdleleni (1990) states that psychiatrists view *amafufunyana* as a type of mental disorder that includes hysteria with psychotic features, mood disorder and schizophrenia. Counselling is perceived as one of the possible cures of 'nerves' such as *amafufunyana* (Mdleleni, 1990). These 'nerves' appear in a broad range of psychiatric disorders including schizophrenia. Medications such as anti-depressants or anti-anxiety remedies are regarded as an effective way of managing psychotic-like symptoms caused by chemical imbalances in the brain (Mzimkulu & Simbayi, 2006; Niehaus et al., 2005).

In contrast, Ross (2010), a South African social worker, uses an Afrocentric model for the interpretation of mental illness and defines it as the spiritual condition of an individual who seems to be deliberately afflicted by witches and sorcerers. "In *amafufunyana*, evil spirits are thought to reside inside a person, and it would be male in the case of a female and a female in the case of a male. Thus, a female possessed would speak in a male voice, and the male possessed would speak in a female voice" (Ross, 2010, p. 45). This suggests that *amafufunyana* is an 'abantu' illness – also

called cultural illness – because traditional healers believe that the illness results from spiritual attacks and requires a traditional African approach to healing (Sibisi, 1975).

Interestingly, trends of witchcraft have occurred in KwaZulu-Natal. The study of Parle and Scorgie (2012) on 'umhaziyo' (a form of witchcraft that attacks young women) is a case in point. 'Umhaziyo' is embedded in the belief that it is man-made by those who had been rejected in love proposals. When a man uses 'muthi', it is believed that it causes some form of psychological dysfunction. This affliction is believed to occur because of witchcraft – similar to the case of *amafufunyana.*

In the context of African traditional healing, witchcraft is the root cause of *amafufunyana* and *umhaziyo* and used for personal gain through manipulating emotions (Parle & Scorgie, 2012). Witchcraft is a reality where inexplicable behaviours seem to occur and cannot be proved through a scientific lens (Parle & Scorgie, 2012; Moshabela, Zuma, & Gaede, 2016). Therefore, traditional healers attribute the cause of *amafufunyana* to supernatural forces which correlates with the findings of studies by Keikelame & Swartz (2015), Mokgobi (2014) and Sibisi (1975).

Extending the biomedical conceptualisation of *amafufunyana*, Niehaus et al. (2005, p. 3) concluded that *amafufunyana* is a "broad concept" often used by Southern Nguni people to allude to forms of depression, aggressive outbursts, hallucinations and delusions. Mdleleni (1990, p. 1) maintains that most 'black psychiatric patients' who present with delusions and hallucinations regard their illness as *amafufunyana*. Lund & Swartz (1998) conclude that in a situation where biomedical psychiatry might not entirely assist, patients try to make sense of their experiences of *amafufunyana* by consulting traditional healers to offer explanations for what has caused the illness.

There is a dearth of literature on the prevention of *amafufunyana*. Biomedical practitioners seem to believe that it is possible to prevent the occurrence of *amafufunyana* through education and awareness campaigns. The campaigns are said to create coping mechanisms since mental illness is not well understood in communities. These efforts serve as an indication of the aims of biomedical practitioners to educate communities on the issues of mental illness in an attempt to reduce its prevalence.

Amafufunyana appears to be a condition that is manifested by a mental state that is regarded as abnormal by both biomedical practitioners and African traditional healers. However, what further makes this illness interesting is the fact that both African traditional healers and psychiatric practitioners attribute the illness to different causes. Therefore, their healing interventions and preventative measures are different. Thus, this study focuses on this seemingly under-researched condition of *amafufunyana*, as stated by Sehoana (2015), to explore the perceptions surrounding it in terms of healing and prevention and the possibilities of mutual collaboration between biomedical practitioners and African traditional healers in a South African context.

There are similarities between African traditional healers' perceptions and the psychiatric understandings of the symptoms of *amafufunyana*. Both African traditional healers and psychiatrists recognise similar symptoms of *amafufunyana* – confusion, attempts at suicide and hallucinations (Mzimkulu & Simbayi, 2006; Niehaus et al., 2005). How these systems lead to the conclusion of *amafufunyana* is based on how the causes are attributed. Traditional healers attribute the causes to witchcraft and sorcery; in contrast, Western psychiatric practitioners attribute the causes to a chemical imbalance in some parts of the brain and abnormal behaviour (Mzimkulu & Simbayi, 2006; Niehaus et al., 2005; Sibisi, 1975).

Cultural interpretations of illnesses are still not included in a Western context because biomedical practitioners make mention of a spiritual element in passing without making spirituality central to their interpretations (Parle, 2003; Moshabela et al., 2016). On the one hand, the traditional or cultural concept of *amafufunyana* is consistently understood as spiritual possession. On the other hand, biomedical explanations of *amafufunyana* consider it an unspecified mental disturbance that remains uncategorised by psychiatric practitioners.

When all is considered, studies from the early 1970s on *amafufunyana* described it as a type of spirit possession or hysteria but, in recent studies, the term is adapted in diverse ways by different sources and informants and it emerges as a complex condition with a cluster of symptoms (Edwards, 1984; Ensink & Robertson, 1996; Campbell et al., 2017; Lund & Swartz, 1998; Mdleleni, 1990; Sibisi, 1975; Staff, 2014; Van de Watt et al., 2020). One of the highlights of this study was the realisation that

the different interpretations of *amafufunyana* indicated knowledge gaps and tensions among researchers. Thus, this study suggests parallel cooperation between biomedical practitioners and traditional healers to bridge these gaps.

Patterns in the conceptualisation of *amafufunyana* change. What is problematic is that the changes are in both the biomedical and African healing paradigms (Parle, 2003). The changes in conceptualisation reflect the complexities of medical pluralism – how healing systems compete and coexist at the same time (Yu, 2021). The literature and the findings of this study also indicate the ongoing discourse on how different healing systems interpret illness differently and how these interpretations may cause confusion about whether *amafufunyana* is a spirit possession or a type of mental disorder. The previous point encapsulates the biopsychosocial model of health which seeks to examine the factors in biology, psychology and socio-environment as to how they influence one's well-being (Burman, 2019). According to (Burman, 2019), the founder of this model – Engels, makes an extension of a biomedical model which tries to account for health seeking behaviour. The biopsychosocial model in its nature tries to address gaps within the traditional form of a biomedical model in trying to adopt a holistic approach in health and illness. For example, this study the biomedical practitioners and African traditional healers try to conceptualise *amafufunyana* by understanding patient's health as to provide a multidimensional approach towards treatment as stated in Chapter Four and Chapter Five.

Parle (2003) makes a similar report about the interpretations of 'indiki' spirit possession which were understood differently and even contested in the late 19th century and throughout the 20th century. 'Indiki' is one form of spirit possession – an individual being possessed by an alien spirit. Sometimes it is said to overlap with 'ukuthwasa' and hysteria (Parle, 2003; Sibisi, 1975; Swartz, 2010). Because of these different views of 'indiki' and *amafufunyana*, this study used some of the contextual meanings of these illnesses to argue for parallel cooperation to bridge the cultural gaps between traditional healers and biomedical practitioners in treating *amafufunyana*.

2.3 Possibilities of collaboration between traditional healers and biomedical practitioners

The purpose of this section is to use the examples of HIV/AIDS and TB to show that successful collaboration between traditional healers and biomedical practitioners towards prevention has occurred. Such a programme has shown that collaboration is possible and beneficial.

Based on the study's findings, some key features of medical integration literature have been located within the context of *amafufunyana*. This study argues that parallel cooperation should be considered as a way of bridging cultural gaps between traditional healers and biomedical practitioners in treating *amafufunyana*. According to Boon et al. (2004) and Mostaghim and Schmeck (2009), parallel cooperation exists when healthcare practitioners work independently of one another in a common practice by negotiating on which cases to work.

In this section, the possibilities of collaboration, medical pluralism and medical integration, are critically discussed to address the research problem of this study. Medical collaboration occurs when all health care practitioners work together to achieve a similar goal and is characterised by sharing responsibility, respect, cooperation and trust (Boon et al., 2009; McDaniel, Campbell, Hepworth, & Lorenz, 2005).

McDaniel et al. (2005) have identified four possible ways of collaboration: formal consultation, informal consultation, co-provision care and parallel delivery. First, formal consultation is a common technique in which a patient has direct contact with a practitioner. Second, informal consultation occurs when a general practitioner consults with other specialists for patient care plans. Third, with co-provision care, a patient maintains relationships with different types of practitioners and these practitioners have a mutual understanding of treatment plans. Lastly, parallel delivery occurs when each practitioner works according to their own scope of practice without overlapping the other practitioner.

Additionally, McDaniel et al. (2005) noted how collaboration is more than just helping which suggests that health practitioners can make arrangements without the need of consulting one another. Their assertion is similar to that of this study because

biomedical practitioners and traditional healers' perceptions converge regarding parallel cooperation; they negotiate on cases on which they could work.

Psychiatric literature stresses on integrating traditional healers and how they could possibly contribute to mental healthcare. For example, Campbell-Hall et al. (2010) call for medical collaboration between African traditional healers and biomedical services. They suggest that the process must be assessed from additional evidence regarding the involvements and understandings of service workers. The study of Lund & Swartz (1998) revealed that Xhosa patients use traditional medicine in conjunction with Western medicine for mental illnesses. The simultaneous use of different healing systems indicates pluralistic tendencies.

Pillsbury (1982) contends that the undeveloped feature of 'cultural distance' between African traditional healers and medically affluent Africans exists. These two groups tolerate each other and their mismatched worldviews of illness. The study concluded that "traditional healing practice is frequently premised on supernatural and other belief systems that are unfamiliar to and not easily understood by biomedical practitioners" (Pillsbury, 1982, p. 1827).

Another factor is the competition and economic value of these two healing systems. Traditional healers seem to be well-established even within cities where biomedicine is dominant (Pillsbury, 1982).

2.3.1 Medical pluralism

Medical pluralism is well-defined as when one or more healing systems coexist in one geographical area (Burman, 2019; Cant, 2020; Uibu, 2020). Around the 1970s, the notion was first coined by Charles Leslie (Yu, 2021, p. 1). The phrase was outlined as the systematic movement with a political agenda that aimed to defend the right of non-conventional healing practices to exist in a world where biomedicine was perceived as being dominant (Moshabela et al., 2016).

The notion of working together in healing systems is important, specifically for this study that explores the perceptions of *amafufunyana* regarding healing, prevention and collaboration between African traditional and biomedical healing systems. Medical collaboration between the two healing systems can see the systems complementing

each other (Adams, Hollenberg, Lui, & Broom, 2009). This was confirmed by Burman (2019) in his analysis of how the relationship between biomedical and traditional healing systems support medical services nationwide. Such an inclusive system that embraces medical integration and where both traditional healing and biomedicine are legally recognised can be adopted (Moshabela et al., 2017).

The complexities of medical integration have been highlighted in some debates that have offered arguments for and against medical integration (Gannotta et al., 2018). These ongoing debates on medical integration are examined in this study by using *amafufunyana* as an example.

Abdullahi (2011), as well as Wiese and Oster (2010), stated that misinterpretation regarding African traditional healers stems from the historical context of witchcraft. The medical history of the Soviet Union associated alternative healers with 'backwardness' (Uibu, 2020). Guan and Chen (2012) state that preachers were predominantly prejudiced towards traditional healers, observing them to be evil and in need of repentance. The absence of the recognition of traditional healers can result in health risks such as cases of treatment toxicity, the inability to manage efficacious treatments (Mulaudzi, 2001; Mokgobi, 2013) and delayed health-seeking and proper treatment (Barker, Millard, Malatsi, Mkoana, & Ngoatwana, 2006).

Some studies in India illustrate the use of the 'pluralistic method' (Biswal, Subudhi, & Acharya, 2017, p. 91). According to Biswal et al. (2017), in the case of mental disorders, traditional healers are the first contact in addressing such conditions; sufferers only resort to allopathic systems later. These researchers mention this because when neither the biomedical practitioner nor the traditional healer gives a clear cause for the disorder, the patient and family will not be able to reject either healing system. A similar observation has been confirmed by Sundararajan, Mwanga-Amumpaire, King, and Ware (2020) regarding this pattern of behaviour in Uganda.

In South Africa, the black middle class has created an informal system of healing by depending on both traditional healers and biomedical systems (Abdullahi, 2011). A study on self-identified traditional healers revealed that it is common practice for such people to consult with the traditional healing system and then use to the biomedical system as an alternative (Van de Watt et al., 2020). This results in delayed treatment

and especially for people living with HIV and individuals who suffer from mental illness this delay compromises treatment protocols (Burman, 2019; Moshabela et al., 2017; Van de Watt et al., 2020). However, the study also revealed that traditional healers were more prone in collaborating with biomedical healing systems in referring patients (Van de Watt et al., 2020).

According to Ross (2010, p. 46), that eight out of ten black African persons would depend on traditional medicine only or use it simultaneously with Western medicine. These pluralistic tendencies in healing have also been noted by Thinwa (2004, p. 31). Seventy per cent of patients with HIV/AIDS and TB use allopathic medicine in conjunction with traditional healing (Moshabela, et al., 2017, p. 3).

Campbell-Hall et al. (2010) state that the incorporation of the traditional healing system into the biomedical healthcare system may expand and transform health-seeking. It was suggested that government start developing a long-term policy towards the formalisation of collaboration and give details on how it should be implemented (Mothibe & Sibanda, 2019). Distinctive strategies of implementation might enable the process and enhance interactions and involvement (Mothibe & Sibanda, 2019). Therefore, it is important to appreciate and acknowledge the coexistence of healthcare systems in ways that could be supportive and helpful to society (Moshabela et al., 2016).

However, other studies question the legitimacy of healing systems that are not conventional (Uibu, 2020; Yu, 2021). This creates hierarchal rather than harmonious healthcare. In essence, medical pluralism highlights the availability of different healing systems and health-seeking behaviour (Uibu, 2020).

Based on the literature above, it is evident that medical pluralism produces unintended consequences which are associated with a delay in diagnosis and interference in treatments especially in the context of HIV/AIDS (Burman, 2019). In light of this problem with medical pluralism, Burman (2019) suggests that perhaps total integration in healthcare and adopting a holistic approach might reduce those unintended consequences. According to Burman (2019), a holistic approach in healthcare seeks to address the patient as a whole by looking at all aspects – the physical, emotional, mental and spiritual aspects.

In contrast, this study uses the ideas of Bodeker (2001) and McDaniel et al. (2005) on parallel integration and argues that parallel cooperation should be considered as a way of bridging the cultural gaps between biomedical practitioners and traditional healers.

2.3.2 Medical integration

According to Rakel (2007), medical integration seeks to emphasise the combination of conventional and alternative medicine in addressing the biological, social, spiritual and psychological aspects of health and illness. Integrative medicine[6] focuses on the partnership of practitioner and patient and collaboration with other practitioners (Gannotta et al., 2018). In addition, medical integration has shown its benefits especially in cases of managing pain (Gannotta et al., 2018).

Biomedicine is dominant because it is financially backed by governments and other institutions such as the WHO especially in the Global North (Cant, 2020; Xu & Chen, 2008; Yu, 2021). Its focus is based on science which means that modern technology is used in health and illness. Biomedicine discourages the use of traditional medicine especially in the context of South Africa (Swartz, 2010). Non-conventional health systems are expected to tolerate and abide by allopathic systems for an effective integrative approach (Ingle, 2009; Uibu, 2020). In the South African context, government has not shown political willingness in regards to integrating African traditional health system towards national healthcare (Mutola, Pemunta, & Ngo, 2021). Political willingness would perhaps would build a more efficient way to regulate African traditional healers and biomedical practitioners in the cases of medical collaboration and integration.

The key aspects considered in facilitating medical integration are well captured by Banfield et al. (2017), Bodeker (2001) and Mothibe & Sibanda (2019). These aspects are the centrality of patient needs, individual multidisciplinary care plans, agreements on interdisciplinary collaboration, alignment of regulatory frameworks, formulating a

[6] This term is said to be interchangeable with medical integration dependent on its geographical use (Rees & Weil, 2001).

standardised practice, training of traditional healers, and sharing of experiences by conventional and non-conventional practitioners.

Regulation in this regard goes hand-in-hand with the registration of traditional healers, monitoring them and evaluating and assessing traditional medicine. To corroborate this, WHO (2008) supported the use of traditional medicine by its member states but with the condition that governments provide policies that align with a regulatory body for the safe use of traditional medicine (Mothibe & Sibanda, 2019). This study uses regulatory challenges to show the complexities in the healing methods of traditional healers and biomedical practitioners for the treatment of *amafufunyana*.

Gannotta et al. (2018) argue that medical integration does not necessarily mean that the service must be delivered in one place. This means that it cannot be based on an all-in-one approach (Banfield et al., 2017). Ingle (2009), as cited in Motloenya (2016), suggests that integration normally occurs in an inclusive or parallel form. In an inclusive approach, traditional medicine is integrated into the national healthcare system; in a parallel approach, traditional medicine and biomedicine are separate from national healthcare (Ingle, 2009). In terms of formulating a standardised practice China, for instance, has adopted an inclusive approach which means that Chinese traditional medicine had to undergo biomedical trials which in turn were included in their health science curriculum and practice (Bodeker, 2001).

In India, a parallel approach is adopted. Indian traditional medicine and biomedicine are separately incorporated in national healthcare. However, Indian traditional medicine had to be standardised based on new regulations that were developed in 2001 to assure quality and safe use (Bodeker, 2001; Mothibe & Sibanda, 2019). The parallel approach resulted in a hybrid curriculum for teaching and learning and did not fit neatly into biomedical and traditional standards (Bodeker, 2001).

WHO (2000) called for 'efficacy testing' because traditional healers have inexplicit ways of testing their medicines. Hence, the reluctance of integrating traditional healing system as its testing procedures are problematic (Cant, 2020). This implies that traditional healing is side-lined while medical hegemony is sustained. Biswal et al. (2017) note similar notions in that the biomedical system prefers the traditional system to apply the same standards used by biomedical practitioners.

This challenge is attributed to secrecy on the part of traditional healers as they do not explicitly give details regarding their processes of healing and the testing of their medications (Mokgobi, 2013; Mothibe & Sibanda, 2019). Traditional healers fear issues of biopiracy amid their growing frustrations about the appropriation of medicinal plants.

According to Mgbeoji (2014), biopiracy is the unauthorised commercial use of traditional knowledge or testing for patents without compensation and acknowledgement. Drawing from Ingle (2009, p. 4), he argues that the process of medical integration constitutes 'cherry-picking' as it seems to embrace the strengths of both healing systems. It is a form of cooperation and collaboration to facilitate the process of medical integration (Dawda, 2019).

Traditional healers and biomedical practitioners share a common goal – to prevent and treat illness. However, they diverge about attributional causes and methods of healing (Train et al., 2007). Each healing system has its own knowledge system, skills and resources which can be used to carry out their roles. Thus, integration between traditional healers and biomedical practitioners holds the promise of improving healthcare (Gannotta et al., 2018; Institute of Medicine, 2012). In healthcare cooperation, McDaniel (2021) explains how to maintain consistency within an organisation and help develop interpersonal skills by reducing conflicts.

Yet, in South Africa, medical integration has not been adopted to form part of mainstream healthcare (Mokgobi, 2013). For this reason, the Traditional Healers Act, No. 22 of 2007 was developed to facilitate the process of medical integration (Mothibe & Sibanda, 2019). The Act aims to regulate and register traditional healers with the Traditional Healer's Council (South Africa, 2008). Moreover, the Act seeks to suggest that traditional healers will be regulated as biomedical practitioners despite their differing belief systems (De Lange, 2017; Moagi, 2009). The pressing challenge regarding the Act is that traditional healers do not register with the Traditional Healer's Council and, therefore, cannot be regulated by the government (Abrams, et al., 2020). This is one of the barriers to a formalised medical integrated healthcare system in South Africa (Abrams, et al., 2020).

Approximately seventy to eighty percent of Africans use traditional medicine as the main source of treatment for their healthcare (Mee et al., 2014, p. 1; Ozioma & Chinwe, 2019, p. 194). This figure suggests that traditional healers are the initial contacts in their setting (Abrams, et al., 2020; Mokgobi, 2013). Patients suffering from HIV/AIDS commonly use traditional medicine as their secondary source of treatment (Peltzer, Friend-Du Preez, Ramalagan, & Fomundam, 2008). However, issues have been raised about the interference of different healing systems being used simultaneously which could reduce the effectiveness of each treatment (Keikelame & Swartz, 2015; Mokgobi, 2014). This normally arises when the cause of the illness is not known (Mokgobi, 2013).

The history of medical integration in illnesses such as TB and HIV/AIDS in South Africa must be examined. Unlike *amafufunyana*, HIV/AIDS and TB are allopathic conditions that have social stigmas and dimensions. HIV/AIDS is incurable and the way it is transmitted has social implications. These factors create knowledge gaps between allopathic versus traditional meanings of illness (Bolton & Gillett, 2019). If the gaps between the medical and the lay narratives of illness are aligned, they seem to provide clarity on the techniques of treatment (Green & Colucci, 2020). These knowledge gaps also exist in the case of *amafufunyana*.

Traditional healers have illustrated their role in the process of adherence to treatments and preventions in HIV/AIDS and TB (Mee, et al., 2014; Zuma, Wight, Rochat, & Moshabela, 2017). This might be crucial in the case of the medical integration of mental health workers for mental health promotion (Campbell-Hall, et al., 2010). In trying to promote an integrative approach, collaboration seems ideal, however, collaborative projects are usually small-scale and normally result in traditional healers withdrawing from the programme (Campbell-Hall et al., 2010; Hlabano, 2013). Nevertheless, "if integration is thoroughly prepared within contextual and cultural realities" (Mothibe & Sibanda, 2019, p. 2), it can be beneficial. In essence, an integrated system is said to be complex, diverse and supportive at organisational and facility levels where there is a sharing of tasks (Mothibe & Sibanda, 2019).

Generally, there is no common ground regarding the definitive meaning of *amafufunyana* among traditional healers and biomedical practitioners. If these

differences are not resolved within and between these two healing systems, total medical integration is not feasible because the condition itself is complex. Thus, this study argues for parallel cooperation between biomedical practitioners and traditional healers.

2.4 Conclusion

In this chapter, a review of the literature demonstrated that traditional healers' views on *amafufunyana* have not changed; the condition is still being viewed as spirit possession resulting from witchcraft. The findings of this study also illustrate that *amafufunyana* is viewed as a spirit possession by traditional healers. The narratives surrounding *amafufunyana* shifted around the early 1990s. Psychology and psychiatry scholars studied patients' experiences and traditional healers' understandings of *amafufunyana* in an attempt to locate it within the Western psychiatric model. From Parle's (2003) argument on 'indiki', it is clear that the shifting conceptualisation of *amafufunyana* is the foundation of this study's argument.

The sections on the perspectives on medical pluralism and its complexities and the process of medical collaboration and medical integration as revealed in previously researched HIV/AIDS and TB studies determined the perceptions of *amafufunyana* regarding healing and prevention and the possibilities of mutual collaboration. In so doing, the possibilities of collaboration in treating *amafufunyana* to yield positive results in healthcare are illustrated.

The following chapter discusses the qualitative research design which guided this study.

CHAPTER THREE

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The purpose of this chapter is to discuss the research design and methodology of this study. This chapter is divided into eight sections: research design, research methodology, research setting and sample size, sampling techniques, techniques of data collection (telephonic interviews), means of analysing data, ethical considerations, and limitations of the study.

3.2 Research design and research methodology

Research is a procedure that reviews available research methods to provide direction in research (Creswell, 2014). Bless, Higson-Smith, and Sithole (2013, p. 131) have discussed the importance of research design "as a way of ensuring high internal validity". It seems that designing is a "methodology is a step-by-step process, and which involves key activities embarked on to implement a chosen research method" (Cassim, 2014, p. 81). Below is a critical analysis of the research design and methodology.

3.2.1 Research design

Hennink, Hutter, and Bailey (2020, p. 9) recommend qualitative research because "it is suitable for addressing the 'why' questions to explain and understand issues or 'how' questions that describe processes and behaviour". Qualitative research approach was used this study because it seeks to focus on the meaning attached to people's experiences/reality (Hennink, Hutter, & Bailey, 2020). According to Bless and Higson-Smith (2000, p. 156), qualitative research is "research conducted, using a range of methods, which uses qualifying words and descriptions to record and investigate aspects of social reality". Thus, qualitative research is quite broad and not informed by a single method. Qualitative research as a formal method of enquiry it seeks to emphasis on context and interpretation of lived realities as it tries to unpack complexities of *amafufunyana* in this study.

Qualitative research explores the 'perspectives of insiders' (Ritchie, Lewis, Nicholls, & Ormston, 2013). The qualitative research method was used to explore the perceptions

of *amafufunyana* held by traditional healers and biomedical practitioners in Hlabisa; thus, it was interpretative in nature (Mokgobi, 2013). The use of this method was ideal in understanding their perceptions and interpretations of *amafufunyana*.

The qualitative approach is time-consuming and a researcher has to listen carefully to place the exact information on record and in field notes (Novick, 2008). This study took three weeks (13/08/2020 to 31/08/2020) to interview all the participants and a further two weeks to transcribe and compile the findings.

Limitations occur in qualitative research. Queirós, Faria, and Almeida (2017) note the practical limitations of qualitative research regarding reliability and validity which can be reduced by assessing interview data which is based on the objectives of the study. Tremblay et al. (2021) identified two ways in which qualitative research is limited within the context of COVID-19 – social distancing and time constraints (curfews) – but recommended a shift to virtual arrangements to promote qualitative research.

Face-to-face interviews were proposed for this study, however because of COVID-19 pandemic restrictions, it was much safer for both the participants and the researcher to communicate virtually through telephonic interviews (Tremblay, et al., 2021). Novick (2008) supports the use of telephonic interviews for an in-depth understanding of a complex reality. In the case of this study, the shift of modes was advantageous because a portion of the sample was a hard-to-reach target so telephonic interviews were cost-effective (Farooq & De Villiers, 2017). The hard-to-reach target in this study are African traditional healers because they are normally based in isolated locations.

3.3 Methodology

3.3.1 Research setting and sample size

Participants from Hlabisa, a small town in the northern area of the rural Umkhanyakude District in KwaZulu-Natal with a population of approximately 2 500, were interviewed. Isizulu is the predominant language in the area with about 96% of the population speaking Isizulu as their first language (Zuma et al., 2017). Previous research by Sloan, Dedicoat, and Lalloo (2007) and Zuma et al. (2017) had been conducted on health-seeking behaviour and traditional healing. The researcher noted that the existing themes of their research would align with this study.

The researcher had prior knowledge of the study area and was aware that there were people who were familiar with the condition of *amafufunyana* in the area. The setting is aligned with the study's intention which was to explore the perceptions of African traditional healers and biomedical practitioners on *amafufunyana* regarding healing, prevention and the possibilities of collaboration.

According to Bless et al. (2013), a study sample is a set of fundamentals taken from the population that is measured to be characteristic of the population. The study had proposed interviewing three psychiatric nurses, two psychiatric doctors and five African traditional healers but during the process of interviewing the psychiatric nurses, the researcher was notified that there was a shortage of specialist doctors in Hlabisa.

Ultimately, the sample comprised 11 participants – five African traditional healers (three faith healers and two herbalists) and six biomedical practitioners[7] (five psychiatric nurses and one neuropsychologist); all were over 18 years. The sample of African traditional healers[8] was not homogenous because their functions vary.

For this reason, it is crucial to keep in mind that there is a distinction between faith healers and herbalists. Faith healers use holy water, candles, and prayer as a source of healing; herbalists practise healing by using their knowledge of medicinal plants – their function is similar to that of pharmacists (Ensink & Robertson, 1996). The selection of sample is underpinned on the basis that psychiatric nurses, faith healers, herbalists and neuropsychologist provide a different range of diagnosis and intervention in mental illness. Based on the saturation principle, this sample size selection verified the researcher's conclusion that she had obtained all the necessary information (Sebele-Mpofu, 2020).

3.3.2 Sampling technique

This study used snowball sampling to identify and recruit participants. In snowball sampling, a researcher collects data on a few identified participants and each

[7] This refers to a broader sphere of health care practitioners which plays a role in treatment of mental illness and *amafufunyana* (Bartholomew, 2018).
[8] This refers to types of African traditional practitioners who provides cultural ways of dealing with illnesses (Mokgobi, 2014).

participant is asked to suggest additional potential participants for interviewing (Bless et al., 2013). Snowballing helps to locate the richest foundation of data to address the research topic. The process of recruiting interviewees involved initiating conversations off the record before commencing with interviews (Hermanowicz, 2002). As a result, the study was able to reach its aim which is demonstrated in Chapter Five.

The researcher used an existing traditional healer contact suggested by friends and relied on word-of-mouth guidance to recruit further participants. Similarly, an initial biomedical key informant was identified and that recruitment motivated other potential biomedical practitioners. The snowballing of referrals was helpful because potential participants were hard to reach under lockdown restrictions (Bless et al., 2013). Without recommendations from initial contacts, the study would have been negatively impacted.

However, snowballing has its limitations. One limitation is that it tends to result in selecting individuals who might 'resemble one another' (Zapata-Barrero & Yalaz, 2018). In this instance, the researcher had multiple contacts so the risk of 'one network' resemblance was reduced (Zapata-Barrero & Yalaz, 2018).

3.3.3 Techniques of data collection

The primary data collection method was telephonic interviews using an interview schedule. As the country was still under lockdown regulations, interviews in the form of appointments suitable for both the researcher as the interviewer and the interviewees were scheduled. Qualitative telephonic data is considered to be rich and detailed and assisted the researcher because the topic presented experiences and expertise.

Under COVID-19 pandemic conditions, telephonic interviews proved to be more cost-effective than travelling which was a quite beneficial. It was ethically appropriate to conduct telephonic interviews so as not to put the researcher and participants at risk (Gillham, 2005). The lack of face-to-face participant recruitment enabled the researcher to communicate in advance with participants (Novick, 2008). Telephonic interviews were used to the researcher's advantage and a relaxed environment was created.

The time dimension is also essential because it locates the time frame of the research (Bless et al., 2013). Three weeks were required to conduct the telephonic interviews. Each interview lasted from 20 to 45 minutes when minimal network disruptions occurred.

3.4 Data analysis

Thematic analysis was used to examine the data. Thematic analysis is a method of analysing, identifying and reporting patterns or themes within data (Braun & Clarke, 2006). Thematic analysis is a basic text analysis technique that assists in answering a research question (Ignatow & Mihalcea, 2016). At its minimum, it involves organising and describing texts in detail by interpreting various identified aspects (Ignatow & Mihalcea, 2016). A theme is a generalisation where the texts containing the words are expressions of that theme (Braun & Clarke, 2006).

Braun and Clarke (2006) identify four steps in the execution of data analysis. The first step of analysing data is to familiarise with the data itself by listening to recordings, going through notes and reading through transcripts. The second step entails coding which is noting patterns in the data and dividing the data to give clarity to detailed content. The third step is to develop identified themes. The fourth step includes the naming and defining of themes and the construction of the report (Braun & Clarke, 2006).

According to Kumar (2011), in qualitative research, researchers are commonly guided by the concept of 'saturation'. Kumar (2011) states that saturation is a period where very little or no new data comes from participants. In this study, saturation was reached when themes reoccurred (Sebele-Mpofu, 2020).

Braun and Clarke's (2006) approach aligned with the study's objective to describe how biomedical and African traditional healers interpret the condition of *amafufunyana*. The themes of the findings were used to argue for parallel cooperation as opposed to medical integration.

3.5 Ethical considerations

According to Wiles (2012), research ethics emphasizes on moral behaviour within the context of research. This study was submitted to the University of the Witwatersrand

School of Social Sciences Committee (SOCL-2020-08) for ethical approval before fieldwork commenced (Appendix D).

In this study, participants were given explanations of the research, for instance, what this research entailed, who was undertaking it and the research objectives. Thus, the participants were informed before the interviews took place (Appendix C). In addition, their verbal consent was required since the interview mode had shifted to telephonic interviews.

Research participants have a right to complete anonymity (Babbie, 2012). In this study, the names of participants were kept anonymous; pseudonyms were used to identify individuals within the data (Appendix B). The information provided by participants has been protected and has not been given to anyone other than the supervisor. The call recordings and transcripts are backed up on the researcher's personal device which is protected with passcodes.

This was a voluntary study; participants were assured that they could withdraw from this study at any moment without being required to offer any explanations (Appendix B). Thus, this study complied with ethical procedures.

3.6 Limitations of the study

The absence of visual cues for both an interviewee and interviewer might mean that messages are not conveyed optimally. However, the absence of visual cues was overcome in this study because the researcher relied on a voice recorder and notes (Sturges & Hanrahan, 2004). Telephone interviews compel both parties to listen carefully to what is said. This is advantageous since it improves communication quality, resulting in fewer misinterpretations (Holt, 2010).

The sampling technique proposed for this study might have introduced a social preferential bias as participants would likely have made referrals to those in the field with whom they were closely familiar (Wagner, Singer, Karimi, Pfeffer, & Strohmaier, 2017). However, biomedical practitioners and traditional healers based in Hlabisa provided information based on their constant exposure to community members and their reality. This assisted to emphasise the perceptions based on their contexts.

At first, the researcher had intended to interview two psychiatric doctors as part of the biomedical practitioners' sample but as interviews progressed, the shortage of specialist doctors in Hlabisa was revealed. For this reason, the targeted sample could not be obtained but five psychiatric nurses and one neuropsychologist were interviewed.

The interview schedule was designed in English but responses were written in the language for which the participant opted. In this case, language was not a barrier as the researcher understood isiZulu. However, translations from isiZulu to English were a setback because of the length of time it took to write up the translations. For validity purposes, an external editor who is fluent in isiZulu and English checked all the translations in the report (Appendix E).

3.7 Conclusion

This chapter presented the qualitative research design that guided this study. The research setting for the context of the subject of *amafufunyana*, the sampling technique which assisted in 'locating' participants, the use of telephonic interviews as the tool for data collection and the thematic analysis for analysing the data were outlined. The ethical considerations for the study were explained and the limitations of the study were also described. The following chapter presents the findings of the study.

CHAPTER FOUR

FINDINGS

4.1 Introduction

This chapter presents the findings of the study. The interviews were conducted telephonically in voice call mode and data were collected using an interview schedule (Appendix A). Eleven participants from Hlabisa were interviewed: five psychiatric nurses, one neuropsychologist, three faith healers and two herbalists. The study had intended to interview two psychiatric doctors but during the process of conducting interviews, the shortage of specialist medical doctors in Hlabisa was discovered. This limited the initial target; however, five psychiatric nurses and one neuropsychologist were interviewed.

Responses were written in isiZulu and English. As a first language speaker of isiZulu, the researcher translated some of the responses from isiZulu to English during the process of writing up this chapter. This was a setback because of the length of time it took to translate. Thematic analysis was used to analyse the interviews.

This chapter presents the demographic profile of the participants and expounds on the ten themes that emerged from the data analysis:

- Mental illness/disorders
- Various causes
- Psychotherapy and anti-psychotics
- Supportive awareness campaigns
- Parallel collaboration: Interests and challenges
- Evil spirit possession
- Witchcraft
- 'Ukushunqiselwa' and prayer
- 'Ukuqiniswa' ritual
- Partnership: Interests and challenges

4.2 Demographic profile of participants

Table 1 presents the pseudonyms of the participants and the categories according to their designation; their age, gender, home language and years of experience of practice are also indicated.

Table 1: Demographic details

Pseudonyms	Designation	Age	Gender	Home language	Experience of practice	Seen a person with *amafufunya-na*?
Venessa	Psychiatric nurse	47	Female	English	23 years	Yes
Ntombizodwa	Psychiatric nurse	59	Female	Isizulu	30 years	Yes
Themba	Psychiatric nurse	40	Male	Isizulu	5 years	Yes
Mandulo	Psychiatric nurse	71	Female	Isizulu	36 years	Yes
Smiso	Psychiatric nurse	40	Male	Isizulu	16 years	No
Prof. Mecko	Neuropsychologist	55	Male	IsiXhosa	22 years	Yes
Ntuli	Faith healer	65	Male	Isizulu	47 years	Yes
Xhakaza	Faith healer	72	Male	Isizulu	27 years	Yes
Nene	Faith healer	46	Male	Isizulu	4 years	Yes
Msomi	Herbalist	86	Female	Isizulu	20 years	Yes
Dorothy	Herbalist	66	Female	Isizulu	25 years	Yes

The sample for this study comprised 11 participants including African traditional healers and biomedical practitioners in Hlabisa (Umkhanyakude District) in KwaZulu-Natal. Of the 11 participants, six were males (55%) and five were females (45%). As this was a voluntary study, the participants engaged willingly. The ages ranged from 40 to 86 years and the majority (n = 9) of the participants had been serving as practitioners for over 15 years. The study revealed that the shortest period in practice of one of the faith healers was four years. The majority of the participants (n = 10) indicated that they had encountered a person with *amafufunyana*.

With 11 participants, the data collected had reached thematic saturation. According to Sebele-Mpofu (2020), thematic saturation is a common yardstick used in qualitative research to ensure its credibility and quality and occurs when a researcher begins to see a similar pattern of responses from participants. Since this study's sample comprised two different professions, saturation was evaluated on the reoccurrence of ideas for each group (Sebele-Mpofu, 2020). For example, the psychiatric nurses defined *amafufunyana* as a mental illness or disorder and the traditional healers defined *amafufunyana* as evil spirit possession. These two healing systems may differ in interpretations, but they shared somewhat similar ideas when identifying the symptoms of *amafufunyana*.

4.3 Biomedical practitioners' perceptions of *amafufunyana*

4.3.1 Mental illness/disorder

Two psychiatric nurses (n = 2) noted that *amafufunyana* was a colloquial term mostly used by patients when referring to a form of psychosis, hysteria or schizophrenia; the other psychiatric nurses and the neuropsychologist (n = 4) viewed the condition as a spiritual illness leading the afflicted to behave pathologically or aggressively. According to Venessa, the condition seems to cause a mental disturbance because it is triggered by stress and depression. She explained:

> *"Amafufunyana is a colloquial term for hysteria. Patients have symptoms of fits, hallucinations, false unconsciousness, excessive behaviour which is out of control and normally seek attention. This concept is actually a feature of these conditions and involves patients experiencing physical symptoms that result from a psychological cause".*

Mandulo reported on additional symptoms which are said to be linked to *amafufunyana* as follows:

> *"It is a spiritual illness that leads to someone being mentally ill and physically ill; a person can present with chronic headache and aggression … and they would speak in a different language and it would be something that one cannot understand; something like a temporary speech impairment".*

In contrast, other psychiatric nurses emphasised that the condition is referred to as abnormal behaviour and remains unclassified under the categories of mental disorders which are triggered by stress, depression and environmental and other biological factors, as the victim isolates himself/herself from reality. For example, Ntombizodwa explained:

> *"It's a type of mental illness because a person who suffers from it has no control of their own being or the way she feels or thinks which means there is some disturbance in the line of thought of that person. I take it as a kind of mental illness, but I do not know how to classify it under the categories of mental disorders".*

Smiso added the same view that the condition of *amafufunyana* erupts as a behavioural issue and revealed the following:

> *"The person would not behave like a normal person would do and that causes some sort of mental disturbance. It is like 'isipoliyane' (a type of mental disturbance linked to amafufunyana) because it has similar symptoms as amafufunyana, and the person suffering is not aware that they have this condition".*

The extracts above represent the biomedical practitioners' views. Their views suggest that biomedical practitioners use a wide range of medical symptoms to conceptualise and diagnose the condition of *amafufunyana*. These accounts imply that the condition of *amafufunyana* starts as a behavioural issue where an individual withdraws from reality but then degenerates into a mental disturbance.

Traditional healers and biomedical practitioners observe one condition with similar symptoms, yet their interpretations of the illness differ. From a biomedical perspective, it is seen as a type of abnormal behaviour which causes a mental disturbance, while from a traditional healing perspective it is some type of spirit possession that mimics a type of mental disturbance. However, a few biomedical practitioners mentioned the

spiritual aspect of the illness although this concept is not central to their definition of *amafufunyana*. This implies that biomedical practitioners hold a dual belief system of illness – that of traditional healing by referring to spiritual illness and that of biomedicine by referring to mental illnesses.

The way biomedical practitioners understand this condition is based on the symptoms that a patient presents rather than the causes. Thus, ongoing tension on how each healing system conceptualises illness – in particular, *amafufunyana* – exists. The tension could be used as an opportunity to employ parallel cooperation as a way to bridge cultural gaps.

4.3.2 Various causes

As far as the causes attributed to *amafufunyana* are concerned, of the six biomedical practitioners, the majority (n = 4) believe that the condition is triggered by stress, depression and environmental and other biological factors. Two biomedical practitioners (n = 2) stated that this condition afflicts someone through acts of dark magic and witchcraft. Ntombizodwa expressed the following:

> *"With amafufunyana, I have heard that it is as a result of dark magic by someone who is conflicted but all in all this person who inflicts this is trying to be in control of the victim's life".*

On the other hand, Venessa gave a differing account by stating:

> *"I think it roots from stress and depression".*

Furthermore, Themba emphasised how the causes differ from case to case. He explained by saying:

> *"Well, the causes differ. In some cases, it's due to head trauma where a patient was previously been involved in a car accident and, in other cases, it is due to a hormonal imbalance where the thought processes of the patient don't function properly. There are also cases of drug abuse which have an impact, for instance, when a pregnant woman drinks alcohol which will then lead to foetal disorder and intellectual disabilities".*

An additional reference to hereditary genetics was made as a causative factor. Smiso explained:

"Sometimes, schizophrenia can be hereditary; there is a dominant gene of schizophrenia that will likely affect the generations to come. That is where we conclude on whether the person is schizophrenic or not".

Judging from the excerpts above, biomedical practitioners believe that the cause is triggered by depression, stress and environmental and other biological factors, such as hereditary genetics. A few of the biomedical practitioners indicated witchcraft as a causative factor, rooting from stories being told about *amafufunyana*. This indicates that their explanation of the cause is not purely based on Western science but is also based on hearsay. In contrast, according to the African traditional healers, *amafufunyana* is caused by witchcraft and sorcery.

4.3.3 Psychotherapy and anti-psychotics

All biomedical practitioners (n = 6) indicated psychotherapy together with anti-psychotic/delusional medication and hypnosis as the method common to all hospitals for treating *amafufunyana*. However, these treatments and how they administer the medications depend on the severity of the symptoms. This was exemplified through the response of Smiso as he explained:

"Firstly, the patient will be given a low dose of psychotropic drugs and then we observe whether the patient responds to the medication or not. If the patient's symptoms are still the same, the dosage of the medication is increased. Both medication and psychotherapy are used in conjunction to treat amafufunyana; in psychotherapy, a therapist will help the patient with coping mechanisms".

Professor Mecko explained that patients have treatment options that are dependent upon the patient's belief system:

"Based on the patient's or family's belief system, a more holistic approach is adopted. However, in a hospital setting, the patient is engaged in psychotherapy of a psychoanalytic nature and hypnotherapy is also used to access the patient's unconscious … well, anti-psychotic medication is the first choice for intervention."

Ntombizodwa supported the use of hypnosis in a case where one cannot establish a causative factor for *amafufunyana*:

"This manipulation of the mind and body enables the psychiatrist to hypnotise a person, to expose the root cause of the abnormal behaviour and also where it originates from".

With regards to the efficacy of treatment, all biomedical practitioners (n=6) stipulated that a patients' assessment is made based on how the symptoms subside. Medications (including barbiturates) may calm the patient down; the use of anti-psychotics is believed to get rid of the patients' delusions and hallucinations.

Professor Mecko affirms the effectiveness of medications by assessing a patient's symptoms in the following way:

"Of course, the person's quality of life would improve, that is, the prominence of symptoms will gradually lessen".

Smiso's response elaborated a different type of technique to assess symptoms when he explained:

"We have a mental state exam whereby we assess and examine the patient by asking questions – such as 'where are you?' and 'can you tell us what it is?' – to check if you are in a conscious state or not … when symptoms subside that's when we know that the patient is better".

From these findings, it is clear that biomedical practitioners share common healing methods that centre around medications, hypnosis and psychotherapy. Their preferred choice of healing method(s) is likely to be effective depending on the symptoms the patient presents. Their responses revealed how they assess medications to determine their effectiveness in the treatment of *amafufunyana*.

Their ways of treating *amafufunyana* are different from those of traditional healers who would use techniques such as prayer, bathing and 'ukushunqisela' (smoke inhalation) in conjunction with medicinal herbs. Both healing paradigms indicate how to treat this condition but are dependent on the severity of symptoms.

In trying to understand *amafufunyana*, one must take into consideration its symptoms and preventative measures as it is widely said that 'prevention is better than cure'. In the following theme, biomedical practitioners share their views on how *amafufunyana* can be prevented.

4.3.4 Supportive awareness campaigns

The majority of biomedical practitioners (n = 4) assert that preventative measures were based on community support awareness, family support awareness and educational campaigns. This was illustrated by Venessa's response:

> "*Patients must have a supportive system from family and school. They must have some activities to engage with and keep busy with".*

At the same time, Themba emphasised how the dangers of alcohol abuse during pregnancy are brought home through campaigns. He described it as follows:

> *"… to educate people through community-based campaigns specifically about pregnancy and substance abuse. Because when a pregnant woman abuses alcohol, this will affect the child from birth. The brain does not develop to its full functionality which then can lead to cases of psychosis".*

Furthermore, Smiso elaborated on the awareness of *amafufunyana*:

> *"Healthcare practitioners do awareness campaigns even though it is something that is not preventable. Awareness in the community helps an individual who presents with symptoms of amafufunyana while the symptoms are still mild".*

A few (n=2) had a different account stating that it is rather difficult to prevent *amafufunyana* as it is believed that the issue of spirit possession is unlikely to be known in depth. For instance, Mandulo explained as follows:

> *"I don't know the ways one could prevent it because the area of spirit hasn't been explored yet … it is very hard to prevent it because not much is known about spirituality".*

Similarly, on the issue of not being able to prevent *amafufunyana* yet, Professor Mecko identified an alternative way to approach prevention:

> *"From a medical perspective, it's difficult to say; however, from an indigenous perspective, it is believed that the person must be fortified (ukuqiniswa) to protect him/herself from evil spirits".*

Biomedical practitioners seem to believe in the prevention of *amafufunyana* through education and awareness campaigns that assist to establish coping mechanisms since mental illness is not well understood in affected communities. This is an indication that

biomedical practitioners aim to educate on the issues of mental illness and try to reduce its prevalence through these campaigns. A few indicated that it is rather difficult to prevent the condition because the medical sector does not cover issues related to spirituality. Another interesting finding is that prevention seems to include social movements involving collaborative work.

Biomedical practitioners share their views on the possibilities of collaborating with African traditional healers in the theme below.

4.3.5 Parallel collaboration

Most of the biomedical practitioners (n = 4) who participated in this study had an interest in collaborating with traditional healers to heal *amafufunyana*. Two biomedical practitioners (n = 2) indicated that they did not have an interest in collaborating even though one of them has a history of working with African traditional healers to whom he had referred patients.

Mandulo's interest in collaboration would be conditional:

> *"Yes, depending on what we would be working together on; I would be selective on cases".*

Another compelling reason Themba added was that collaboration must be in support of patients who have different belief systems, for instance:

> *"There are people who do not believe in Western medicine and believe in traditional healers so if we can work together with the traditional healers to assist patients ..."*

The other feature of willingness to collaborate was based on holistic ways of healing. This is shared by Prof Mecko in the following:

> *"Their method is more holistic and, depending on the traditional healers, some do recognise limitations in their approaches".*

The views of the biomedical practitioners on the challenges to collaboration centred on how African traditional healers apply different knowledge systems in their healing methods and the issue of referring patients when cases had worsened.

Ntombizodwa's reasoning for having no interest in collaboration was based on the fact that the Hlabisa hospital did not permit and had not engaged with traditional healers regarding collaborations:

> *"… some other practices in health … we discourage them like having to refer a patient to a traditional healer".*

The matter of referring the patient to the hospital in time was stipulated together with the need for the formalisation of collaboration between biomedical practitioners and traditional healers. The DoH has an essential role to play in overseeing that duties are carried out effectively. Smiso clarifies:

> *"The challenges would be on the issue of referring a patient in time. The hospital will be reluctant to refer the patient to the traditional healer because of different cultural beliefs. Secondly, it could be the level of training of traditional healers. If possible, the Department of Health could formalise it properly".*

The factors on differing techniques between biomedical practitioners and traditional healers are seen as another challenge to collaboration. As Themba explains:

> *"There will be issues of adaptation because the healing methods are not the same. So instead of being able to work together, we would end up competing with one another".*

Prof Mecko had a different account. He believed that not enough research had been done regarding traditional ways of healing:

> *"I wouldn't refer a patient to someone whose techniques and methods of interventions have not been researched".*

Furthermore, the issue of the trustworthiness of working with registered traditional healers was raised as a challenge to the possibility of collaboration. Smiso stated:

> *"Yes, but not with bogus traditional healers and only if there would be a commonality in ways of diagnosing".*

The challenge is that traditional healers have their own knowledge system which differs from biomedicine. Traditional healers also do not fully explain the side effects of their medications. The issue of patients arriving at hospitals when their conditions have worsened is seen as a hindrance to forging mutual collaboration. To support this,

Mandulo gave an account of the challenging factor of different knowledge systems between biomedical practitioners and African traditional healers:

> *"In my understanding, it is very difficult working with someone who has a different type of knowledge system. This is an issue because traditional healers do not explain the side effects of their medications".*

According to Venessa, traditional healers refer patients when they are at their deterioration point and that reiterates Smiso's viewpoint about referring patients in time:

> *"Patients are always in a critical state of renal failure when they come from consulting with a traditional healer. It means they cannot treat patients properly because they refer them to the hospital".*

Biomedical practitioners do have an interest in collaborating with African traditional healers in support of the patient but only on selective cases. This is because biomedical practitioners are in doubt about the techniques used by traditional healers. Additionally, they complained about cases of patients only seeking biomedical intervention when they are in a critical condition which in turn influences the health-seeking behaviour of patients. This implies that patients start by seeking treatment from traditional healers and only then resort to allopathic health systems.

Since there is no commonality in their techniques of treatment, biomedical practitioners are therefore interested in a parallel cooperative relationship rather than mutual cooperation with traditional healers.

In the following section, African traditional healers share their perceptions of *amafufunyana* and the possibilities of collaboration.

4.4 African traditional healers' perceptions of *amafufunyana*

4.4.1 Evil spirit possession

According to all the African traditional healers (n = 5), *amafufunyana* is contextualised as a demonic and evil spirit possession that normally resides in a young female and is caused by acts of witchcraft because the person who inflicts this wants some sort of control over the victim he claims to love. According to Xhakaza, this condition is prevalent among females although a few cases of males who experienced it have been

noted. The symptoms of males suffering from *amafufunyana* are said to be similar to those of females, but its intentional causes differ; the cause in the case of males is believed to be 'ibulawa' which means someone is seeking revenge or wants to see one dead.

Amafufunyana is said to be a 'medically invisible' condition because a medical institution will not be able to detect any spiritual illness because, although it mimics 'ukuhlanya' (madness), the symptoms differ. In *amafufunyana,* a person afflicted will cry hysterically, become violent, always seek a fight, be anti-social and run away as if being chased by someone.

An interesting finding was that traditional healers made a distinction between violent and silent forms of *amafufunyana*. According to Dorothy, the violent form of *amafufunyana* manifests as a person speaking in a foreign language and being aggressive; in the silent form of *amafufunyana*, the victim is usually tired and does not want to socialise. The silent form is not easily identifiable but can be revealed through the process of 'ukuphahla' (divination). For example, Xhakaza defines it in the following manner:

> *"Amafufunyana is a man-made condition caused by a male seeking love from a young female. The person uses potions of different kinds which disrupt her ancestral spirit. It is closely related to 'izizwe' (a type of medicine used to create evil spirits) and 'isipoliyane' because a person with it cries non-stop and it seems as though the person is psychotic but is not".*

Dorothy made a similar point on the identifiable symptoms of *amafufunyana*:

> *"Amafufunyana is when a person is spiritually attacked by evil spirits and we call that 'unezilwane' (familiars). This condition causes a person to cry and start to run away from home; sometimes the person roars like a lion".*

She further added that 'izizwe' is a type of medicine that attracts evil spirits. The possessed person will 'speak' in different languages and one would not understand what the person is trying to articulate.

Amafufunyana is said to be the wandering spirit of the victim. One of its identified symptoms is social withdrawal and tiredness. Msomi labelled it in the following way:

"This condition of amafufunyana makes someone wander around; it's an evil spirit that does not sleep. It causes a mental disturbance as though someone is going crazy".

Traditional healers identify this condition by causal factors which are centred around witchcraft and sorcery. They perceive *amafufunyana* as a spiritual illness that dislocates one's ancestral spirit and leads to some sort of mental confusion or disturbance. Their explanation is rooted in why the person may have the condition and how it may have been triggered.

Traditional healers can identify with any form of *amafufunyana* and apply their own strategies to calm the victim and later treat the condition. However, biomedical practitioners view *amafufunyana* as varieties of mental disorders and link schizophrenia and hysteria erupting from stress and other factors to the condition. These two healing systems have observed similar symptoms of *amafufunyana* such as social withdrawal, speech impairments and aggression. However, their interpretations of the condition are different. The traditional healers' explanation of *amafufunyana* seems to be based on the causes of the condition which will be further discussed in the next theme.

4.4.2 Witchcraft

All the traditional healers (n = 5) expressed that the cause of *amafufunyana* is witchcraft. Its attribution to witchcraft is rooted in the belief that an afflicted person may be seemingly disconnected from their ancestral spirits, hence, their observation of abnormal behaviour. Nene explained:

"Amafufunyana is caused by an evil spirit that is no longer in the living world so that spirit is brought by someone else through acts of witchcraft".

The elements of jealousy and anger and a sense of control seem to be the central features of the witchcraft perpetrated against the afflicted person; this belief was highlighted in Dorothy's response:

"This condition is caused by a jealous person who doesn't want to see anyone's success then they inflict you with evil spirits to hinder and slow down an individual's potential to their future".

Some forms of witchcraft, such as casting spells and the use of dark potions, seem to attract evil spirits. Xhakaza stated:

> *"People can cast a spell by using words and using specific 'muthi' to cause harm and that's when a person starts presenting with abnormal behaviours".*

Traditional healers attribute the cause of *amafufunyana* to witchcraft. According to them, as an evidence-based theory, it is hard to detect by those who do not work with spiritual entities. The cause of *amafufunyana* can be determined by 'ukuhlola' (divination); a traditional healer will see visions regarding the patterns of *amafufunyana*. Their beliefs are based on the central features of jealousy, anger, and the victim's spiritual disconnection from their ancestral spirits. Their treatment interventions include techniques such as 'ukushinqisela', bathing and prayer in conjunction with medicinal plants.

4.4.3 'Ukushunqisela' and prayer

In consideration of the attributional causes of *amafufunyana*, traditional healers seek to treat and heal first spiritually by implementing 'ukuhlohla' and using 'imphepho'[9] (Helichrysum odoratissimum) – commonly known as incense – to communicate with the patient's ancestors in revealing the illness and its origin. The common (n = 5) treatment and healing of *amafufunyana* are by using holy water and 'imphepho'. However, their techniques of healing might differ in form and can include inhalation, induced vomiting or bathing using medicinal herbs.

For example, Ntuli enlightened on the treatment procedures of holy water and medicinal plants:

> *"I take 'isiwasho' (holy water) and bathe her in cold water mixed with 'imphepho' and that's where this evil spirit speaks and tells me how it got to this person and who is responsible; so I pray to remove such spirits away".*

Dorothy mentions that techniques of treatment depend upon the type of *amafufunyana* the victim presents:

[9] Licorice plant

"… depending on the kind of amafufunyana a person has, sometimes a patient has to inhale 'imphepho' together with 'izinyamazane' (powered medicine made up from a variety of dried animal parts)".

Similarly, Xhakaza reiterates the technique of 'ukushunqisela' but with a different type of medicinal plant when he states:

"One main treatment for a person with amafufunyana is through 'umuthi owukushunqiselwa' (smoke inhalation) where she has to inhale 'inkuphulwane'[10] (Haemanthus magnificus) and 'izinyamazane' in its powered form through her nose".

Holy water is seen as a powerful repellent that consists of a mixture of sea water, fresh water and ash over which has been prayed. For example, Nene simplified its use in the following way:

"… 'isiwasho' and prayer helps, and the patient needs to stay with me for a period of time so that I can keep an eye on her and how the situation progresses".

Regarding the effectiveness of treating *amafufunyana*, all the traditional healers (n = 5) said that they observe the victim for some time, so an afflicted person has to reside in the household of the traditional healer. They use other unnamed medicinal plants to test if the victim responds and to test whether the symptoms have been reversed or not. As Ntuli explains:

"In the first consultation, you can see by the eyes of the victim that they're not in a normal state. So, after giving them isiwasho, symptoms will not be there … there is umuthi one can use to test. If a person does not sneeze, then it means that umuthi has worked".

The process of healing among faith healers is through acts of exorcism – prayer, bathing or drinking holy water and *'imphepho'* – to remove evil spirits. On the other hand, herbalists do not use prayer but use a variation of medicinal plants and healing techniques such as *'ukushunqisela'*, bathing and 'ukuphalaza' (induced vomiting). Thus, the healing techniques vary from one type of traditional healer to another.

In contrast, biomedical practitioners seem to focus on drug medication with psychotherapy and hypnosis. This means that there is a treatment gap between

[10] Blood lily

traditional healers and biomedical practitioners because of their different techniques. The treatment gap that results from their divergent healing systems is informed by their different knowledge systems. Traditional healers' preventative measures to avert spirit possessions are deemed to be a form of ritual cleansing. To repel the evil spirits that cause *amafufunyana*, a ritual called 'ukuqiniswa' is used.

4.4.4 'Ukuqiniswa' ritual

All the traditional healers (n = 5) referred to a ritual called 'ukuqiniswa' which is a protection and strengthening against evil spirits. According to traditional healers, this ritual consists of the application of medicinal plants to incisions made to body joints.

Nene revealed that in a situation of 'ukucupha' (to trap someone), the intended afflictions return to the sender by the use of prophetic ropes. Through the technique of 'ukuqiniswa', one can prevent the evil spirits from causing *amafufunyana*. In his response, Nene stated:

> *"This ritual repels evil spirits by the use of a small red rope around one's waist. There is another plant called 'ivimbela' (a Vaseline-based medical herb) one could use as well".*

Dorothy describes the processes of 'ukuqiniswa' as follows:

> *"You can consult with a traditional healer who will make incisions on your body joints and smear them with a specific 'muthi' to repel any kind of witchcraft".*

According to traditional healers, 'ukuqiniswa' is both a preventative and protective measure to block any harm or misfortunes in the future. This ritual is believed to be effective when it comes to repelling evil spirits which are associated with witchcraft, especially with *amafufunyana* because of their belief system on spiritually caused illnesses. The medicinal plants that are applied in the incisions serve as a protective guard against evil spirits.

On the one hand, traditional healers believe that through 'ukuqiniswa' a spiritually induced illness can be prevented. On the other hand, biomedical practitioners seek to prevent *amafufunyana* through educational and community-based awareness campaigns.

In the next theme, the traditional healers who participated in this study share their perceptions of the possibility of mutual collaboration with biomedical practitioners to treat *amafufunyana*.

4.4.5 Partnership

All the traditional healers (n = 5) shared their willingness to engage in future collaboration with biomedical practitioners. Two traditional healers (n = 2), who are currently working with private medical doctors in the area, have expressed how it could benefit the patient as some illnesses are medically invisible. For instance, Dorothy has a history of working at a hospital to do check-ups:

> *"I do work in hospitals from time to time to check patients I referred, and I work with a CHO (Community Health Officer)".*

Three of the traditional healers who had indicated their willingness for collaboration (n = 3) indicated that their willingness came with conditions. They were adamant about implementing their own techniques to promote the traditional ways of healing. Xhakaza explains in the following:

> *"I would work with medical doctors only if they would allow me to treat patients my own way and not use their methods from the West".*

Msomi indicated that she is willing to refer patients in cases where she cannot treat a patient:

> *"Since the world is changing, I would like to work with them but only to refer patients where I can tell that I cannot treat the illness".*

The challenges one might foresee in traditional healers working together with biomedical practitioners would include the biomedical fraternity's inability to detect spiritual illness and, therefore, the clash of their cultural beliefs. For example, Nene explained:

> *"I think issues might arise because doctors tend to have a different belief system to ours; they believe in science … other illnesses are revealed by ancestors and I cannot prove that to a doctor".*

Xhakaza mentions that some illnesses are 'medically invisible' which is another of the challenges of working with biomedical practitioners. He mentioned the following:

"What I can say is that medical doctors cannot tell if a person has a spiritual possession so that's the issue".

The other challenge is the lack of reciprocity from biomedical practitioners about referring patients to traditional healers. For instance, Ntuli stated:

"Even though I work with private doctors, my only problem with them is that they do not make referrals back to me, but I do make referrals to them".

The majority of traditional healers stated that Western scientific testing of traditional medicine is problematic but that they were willing to collaborate with the medical mainstream. However, the lack of trust between these two healing systems cannot be overlooked. Msomi reiterates this point by stating:

"I wouldn't want doctors to test my herbs because that would mean that they are undermining my work".

All the traditional healers (n = 5) indicated their willingness to collaborate with biomedical practitioners on the condition that no interference in their methods and no tests on their medicines would occur. Therefore, the traditional healers seek a partnership rather than total medical integration even though they foresee challenges such as their different cultural beliefs, lack of reciprocity and in some cases the lack of understanding of spiritual illnesses on the part of biomedical practitioners. The biomedical practitioners opt for cooperation from traditional healers.

4.5 Conclusion

This chapter answered the study's research question and sub-questions. These questions were aligned with the themes of the study's findings. The main research question is stated as follows:

1. What are the perceptions of African traditional healers and biomedical practitioners on healing and prevention and the possibilities of mutual collaboration on *amafufunyana* in Hlabisa?

The sub-questions are:

2. How do African traditional healers and biomedical practitioners understand *amafufunyana*?
3. In what ways is the condition of *amafufunyana* treated?

4. How can African traditional healers and biomedical practitioners identify ways of collaboration in the treatment of *amafufunyana*?

This chapter presented the demographic details of the participants and presented the ten themes that had emerged from the findings. Biomedical practitioners perceive *amafufunyana* as some sort of mental illness, ranging from hysteria to schizophrenia, which is potentially triggered by stress and depression. In contrast, traditional healers observe this condition as evil spirit possession that is caused by witchcraft and sorcery. The findings of the study are used to argue for parallel cooperation.

The following chapter discusses the study's findings in terms of the ongoing debate between African traditional healers and biomedical practitioners on medical integration and proposes the adoption of parallel cooperation as a viable alternative.

CHAPTER FIVE

CHALLENGES TO MEDICAL INTEGRATION: IN SEARCH OF PARALLEL COOPERATION AS AN ALTERNATIVE

5.1 Introduction

This chapter secures the findings of the study in the enduring debate on medical integration using the condition of *amafufunyana* and its implications as an example. The challenges surrounding medical integration will be demonstrated and the need for parallel cooperation among biomedical practitioners and African traditional healers suggested. This chapter details the five identified aspects of medical integration: (a) contextual meaning of illnesses, (b) regulatory challenges in medical integration, (c) the role of government in providing supportive structures, (d) standardised practices and (e) collaboration.

Medical integration seeks to emphasise the combination of conventional and alternative medicine in addressing the biological, social, spiritual and psychological aspects of health and illness (Rakel, 2007). Furthermore, medical integration focuses on the partnership of practitioner and patient and the collaboration with other practitioners (Gannotta et al., 2018). In South Africa, debates on medical integration have shown its importance in the prevention and treatment of HIV/AIDS and TB; traditional healers had to incorporate medical elements, such as providing medical gloves and condoms, in their practices (Mee et al., 2014; Zuma et al., 2017).

The researcher's interest in medical integration was piqued by the claim that the "merging of traditional and biomedical healing paradigms provides a complementary system of plural healthcare which could offer patients a holistic and comprehensive form of healing" (Moshabela et al, 2016, p. 83). Ingle (2009) as cited in Motloenya (2016) suggests that integration normally occurs in an inclusive or parallel approach. In an inclusive approach, traditional medicine is integrated into the national healthcare system but in a parallel approach, traditional medicine and biomedicine are both legally recognised but practised separately within the national healthcare system. Ingle (2009) goes further and raises a concern about whether the promotion of medical integration is merely based on the interaction of different healing systems or on fully merging them.

This study's thesis statement lends from Ingle's (2009) view on the parallel approach which argues for parallel cooperation between biomedical practitioners and traditional healers. According to Boon et al. (2004) and Mostaghim and Schmeck (2009), parallel cooperation exists when healthcare practitioners work independently of one another in a common practice by negotiating on which cases to work.

5.2 Contextual meanings of illnesses

This section highlights the challenges posed by the lack of a standardised meaning of *amafufunyana* in forging an integrated healthcare system. The challenge of standardised meaning will be framed through the different meanings of *amafufunyana*. These meanings will be based on the perspectives of biomedical practitioners and traditional healers. The different attributes of *amafufunyana* inform these different meanings. Placing *amafufunyana* into a South African context will provide reasons for the problem of arriving at a standardised meaning.

When comparing the conceptualisation of *amafufunyana,* traditional healers and biomedical practitioners have different views. The concept of *amafufunyana* is not used by biomedical institutions yet biomedical practitioners can interpret it. That a*mafufunyana* is based on spirit possession is the view of traditional healers and dates back to the early 1970s. Biomedical practitioners view *amafufunyana* as a variety of mental illnesses. This indicates conflicting notions about the concept.

Biomedical practitioners and African traditional healers are cognisant of the different contexts in the diagnosis and interpretations of *amafufunyana* and this awareness presents a barrier to medical integration. The application of contextual meaning, as Wong, Gaster, and Lee (2012) argue, is an advantage for integration and differs from this study. According to biomedical practitioners and traditional healers, their knowledge systems inform their practices, hence, the different interpretations of *amafufunyana*. The different ways in which *amafufunyana* is contextualised causes difficulties for the integration of the biomedical and traditional healthcare systems.

Studies demonstrate that medical integration occurs when standardised meaning and terminology is developed (Bodeker, 2001; Ingle, 2009; Taib & McIntosh, 2010). The findings from this study suggest the improbability of developing a standardised meaning and terminology for *amafufunyana* because biomedical practitioners believe

that any form of spirit possession is a major source of mental illness while traditional healers still maintain that *amafufunyana* is evil spirit possession. A key and problematic feature is that spirit possessions tend to be portrayed in Western psychiatry as idioms for explaining distress and mental illness whereas, in the traditional healing system, spirit-related issues can actually cause abnormal behaviour.

Bodeker (2001) argues that the process of medical integration is problematic by focusing on the factor of modernisation which seems to diffuse traditional theory. He concludes that traditional concepts would be lost and replaced if traditional healing were integrated into the national healthcare system. Biomedicine would therefore dominate because it has the advantage of being financially supported by the government and other institutions such as WHO especially in the Global North (Xu & Chen, 2008).

In defining *amafufunyana*, biomedical practitioners prefer to relate the condition to a variety of mental illnesses instead of merging the belief systems of their patients; traditional healers view it as evil spirit possession. The naming of an illness automatically gives a diagnosis (Ngqila, 2015). However, in a biomedical setting, one must give a self-report on the symptoms of *amafufunyana* whereas traditional healing focuses on the causes of *amafufunyana*. Biomedical practitioners do not use the concept of '*amafufunyana'* in their settings. To them, it is a wide range of symptoms that are placed under psychiatric disorders. This is an indication that the biomedical sphere is not inclusive because it does not integrate cultural literacy into the medical mainstream (Campbell-Hall et al., 2010; Keikelame & Swartz, 2015).

The emphasis of Train et al. (2007) on cultural relativism suggests that behaviour in the case of illness differs from culture to culture. They highlight that Westernised professions, such as psychology and psychiatry, are products of modernisation and that the systems of diagnosis used by these professions are not useful outside of Western culture because of context.

Contextual meaning generates an understanding of the different meanings of *amafufunyana* from the perspectives of biomedical practitioners and traditional healers and informs their differing techniques in healing and prevention. Yet, biomedical

practitioners and traditional healers view their different systems as barriers to achieving a similar goal.

Perhaps the parallel cooperation of traditional healers and biomedical practitioners would yield a mutual understanding of *amafufunyana* in terms of managing the condition. Parallel cooperation is feasible if both healing systems with their different knowledge systems could be brought to mutual understanding by the official initiation of engagements. In this study, the views of traditional healers and biomedical practitioners on conditional ways of working together within a parallel system converged.

Biomedical practitioners treat *amafufunyana* by seeking to address behavioural and mental issues whereas traditional healers seek to address spiritual and behavioural issues. These treatment protocols are based on the contextual meanings each group subscribes to and mostly stem from the abnormal behaviour witnessed. Abnormal behaviour is a determinant of mental illness, but it does not necessarily mean one suffers from mental illness (Mdleleni, 1990). Spirit possessions, as explained by traditional healers, are totally different from mental illness.

If the example of the successful medical integration achieved in HIV/AIDS and TB is considered, total integration depends on the nature of the condition itself. In HIV/AIDS and TB, a mutual understanding regarding the nature of the condition seems to prevail. However, the different interpretations of *amafufunyana* by biomedical practitioners and African traditional healers seem to interfere with the possibility of medical integration (Moshabela et al., 2016).

The identified gaps point rather to the need for parallel cooperation. Gaps could be bridged if all involved learnt from each other and the result would be an inclusive healthcare system. For example, traditional healers would state how they identify spirit possessions and biomedical practitioners would state how they identify mental disorders. This would mean that they would still practice independently but be working together on a case-to-case basis (Boon et al., 2004). Ultimately, in this context, total integration is not feasible because the nature of the condition of *amafufunyana* is too complex. Perhaps the vision of parallel cooperation should be addressed by looking at the challenges posed by a regulatory system to medical integration.

5.3 Regulatory challenges to medical integration

Regulation in medical integration is a prerequisite to assure that healthcare professionals work together efficiently and that certain standards are followed and observed (Mothibe & Sibanda, 2019). At first glance, regulation appears to be a simple yet key feature of healthcare, however, when looking at African traditional healing, one can tell that regulation is complex. In the context of this study, regulation confirms how it favours medical integration. Therefore, this section argues that regulation is a complex process that entails challenges that are not being addressed.

To explain the processes of medical integration, Mothibe and Sibanda (2019) start by addressing the issue of assessing and monitoring traditional medicine in an attempt to tackle safety issues. This study is also concerned about the efficacy and safety of the healing methods implemented for *amafufunyana*. Biomedical practitioners say that traditional medicine ought to be tested; traditional healers state that their medicine should not be tested. This contention points directly to the need for the regulation of the African traditional healing system. The divergence on regulation creates tension between biomedical practitioners and African traditional healers.

One of the reasons for the regulatory challenge is that traditional healers are not being monitored even if they register with the Interim Traditional Health Practitioner's Council (Abrams et al., 2020; Mothibe & Sibanda, 2019). However, this study's focus was on the practice of biomedical practitioners and traditional healers and the scope of this study did not cover their registration status.

The challenge of an unregulated system makes it difficult to differentiate between registered traditional healers and bogus ones, hence, the argument for the standardised regulation of traditional healers to comply with biomedical practitioner's standards. The standardisation imperative is supported by the argument of biomedical practitioners that traditional healers do not have a unified system but rather practise according to their various cultural contexts (Pemunta & Tabenyang, 2020). A regulatory framework helps to avoid malpractice and delayed diagnosis.

Traditional healers claim that biomedical practitioners cannot detect *amafufunyana* and, therefore, cannot treat the condition. The reasoning behind this statement is that biomedical institutions cannot detect a spiritually caused illness. What traditional

healers mean is that the government lacks practicality in the regulation of spiritual healing (Moagi, 2009). The challenge lies with the Traditional Health Practitioners Act, No. 22 of 2007 which was aimed at regulating traditional healers (Moagi, 2009). Moagi (2009) argues that the guidelines on measuring spiritual healing methods are still unclear. What seems to be problematic is that the guidelines on regulation do not address the realm of spirits in which traditional healers operate (Mothibe & Sibanda, 2019). The findings of this study suggest that the potential challenge to parallel cooperation is that traditional healers will continue to self-regulate which poses the threat of delayed diagnosis while biomedical practitioners remain regulated by the government.

The proposed regulation of African traditional healers was set through a single-sided scientific lens. One of the issues which were highlighted in the Traditional Health Practitioners Act was the lack of standardised practices and compliance by traditional healers (De Lange, 2017). This is an indication that the government intends traditional healers to operate in an integrated system but traditional healers are not complying with the Act (Wreford, 2005). Therefore, integrating traditional healers in the context of *amafufunyana* is not possible.

In turn, biomedical practitioners say that there is normally a delayed diagnosis in the case of *amafufunyana*. This argument arises from traditional healers not being integrated into mainstream healthcare. The risk occurs when patients consult with two different healing systems at the same time. These pluralistic tendencies result from the different attributions attached to the cause of *amafufunyana*. Patients end up being conflicted because the cause of *amafufunyana* cannot be determined. In addition, the inability to determine which healing approach was effective is an identified challenge to an integrated health system (Bodeker, 2001). Parallel cooperation might be the feasible option to avoid situations where one healing system dominates over the other because traditional healers and biomedical practitioners could work independently and their practices need not overlap.

Another challenge is that traditional medicine is not clinically tested and, therefore, conflicts with biomedical practitioners' expectations (Moagi, 2009; Mothibe & Sibanda, 2019). Medical integration advocates that traditional medicine undergo clinical trials

and apply similar standards to those of allopathic medicine to ensure efficacy and safety. As Ingle (2009, p. 5) argues: "With regulation, the regulated must subject themselves to a measure of discipline – they cannot simply opt out of playing by the rules when it happens to suit them."

The previous quote fits the narrative because it implies that traditional healers must abide by biomedical practitioners' standards which seems biased. Regulation in this context helps one to understand that it is a broad field and that perhaps the South African government must provide alternative ways of regulating traditional medicine according to traditional healing standards (Moshabela et al., 2016).

No consensus regarding the definitive meaning of *amafufunyana* among traditional healers and biomedical practitioners exists. If these differences within and between these two healing systems are not resolved, these systems will not be able to operate in the same scope of practice. Challenges in regulating traditional healers make it difficult for the government to implement integrative policies in healthcare although the Traditional Health Practitioners Act, No. 22 of 2007 (South Africa, 2008) laid the foundation towards the possibility of medical integration.

In contrast, one might also argue that parallel cooperation would conflict with the existing policy on regulating traditional healers. The challenge would be how the government would regulate on a case-to-case basis. To date, the format of formalised collaboration is still unclear (Hlabano, 2013; Van de Watt et al., 2020). Therefore, the government must institute clear guidelines because the existing Traditional Health Practitioners Act contains potential loopholes. The following aspect of this discussion looks at the role of government in providing supportive structures.

5.4 Role of government in providing supportive structures

Extending on the point of regulation, this section explores whether government provides supportive structures in healthcare to encourage the process of medical integration. The process refers to accommodating traditional healers within the national healthcare system (Mothibe & Sibanda, 2019). The study's findings on the challenges to collaboration indicate that the different knowledge systems of the biomedical practitioners and traditional healers regarding the causes of *amafufunyana*

are at the root of the problem. What seems to differ is how they attribute the different causes to *amafufunyana*.

Biomedical practitioners in this study attribute the cause to various factors such as stress, depression and biological and environmental factors. In contrast, traditional healers attribute the cause of *amafufunyana* to witchcraft. Moreover, they noted that it might be difficult to adapt to a new knowledge system since knowledge systems are deeply rooted in cultural beliefs. The challenges to collaboration were ascribed to the government's inadequate efforts in reconciling these two disparate healthcare systems. Therefore, the findings of this study assert that structural support from the government is still lacking, hence, the difficulty experienced in forging an integrated health system.

Reflecting on the study's findings on the question of non-collaborative relations, biomedical practitioners believe that the DoH is reluctant to work with traditional healers. Traditional healers say that there has not been any engagement with formal institutions concerning collaboration. Regarding the issues on regulation, it is apparent that the government has provided a well-established regulated system for biomedical practitioners but not for traditional healers. However, both traditional healers and biomedical practitioners expect the government to initiate the process of integration formally (Mothibe & Sibanda, 2019).

Biomedical practitioners in this study proposed that the DoH formalise collaboration. However, support is one-sided because biomedical practitioners in this study are fully supported by the government, but traditional healers are not supported. The government seems to support ideas about medical integration; however, this support remains only at policy level without implementation (Moagi, 2009; Mothibe & Sibanda, 2019). The government, however, cannot be the sole supporter of this process; the Health Professionals Council of South Africa (HPCSA), the Traditional Healers Council and other stakeholders should be active role players (Mokgobi, 2013; Mothibe & Sibanda, 2019).

Limited engagement in expert 'task sharing' among traditional healers and biomedical practitioners occurs. If the issue of the treatment gaps between them could be mitigated, wider access to healthcare could be offered. Depending on the involvement

of the government, parallel cooperation as a starting point might lay the foundation to address the regulatory challenges at a grassroots level. In parallel cooperation, traditional healers and biomedical practitioners expect to work both independently and jointly on a case-to-case basis. However, the literature reveals that the government indicates the limited resources at its disposal for healthcare, especially in the specialisation of healthcare workers (Mokgobi, 2013; Suter, Oelke, Adair, & Armitage, 2010).

The role of the government in providing supportive structures is not evident because of existing constraints such as the absence of policies on medical collaboration and integration and the lack of implementation. The government's role in providing supportive structures is inadequate and a shortcoming in any attempt to engage in collaborative projects (Campbell-Hall et al., 2010; Hlabano, 2013; Wreford, 2005). By implication, the government's inadequacy underscores the traditional healers' continued adherence to self-regulation without any governmental interference. As suggested by the study's findings, limited supportive structures for facilitating parallel cooperation are available.

5.5 Standardised practices

Standardised practices in medical integration refer to enforcing evidence-based approaches in common care (Bodeker, 2001). Rakel (2007, p. 9) notes that "medical integration encourages more time and effort on disease prevention instead of waiting to treat disease once it manifests". In this section, standardised practice is discussed by emphasising the preventative measures that should be implemented for *amafufunyana*. The idea that standardised practice challenges medical integration will also be considered.

The process of standardisation is said to ensure quality and safety in healthcare (Scheid & MacPherson, 2011). The concept of standardisation can be traced back to the initial processes of biomedicine (Pemunta & Tabenyang, 2020). This means that in medical integration, traditional healers must comply with guidelines provided by the DoH. For the traditional healers in this study, standardisation in the context of medical integration is problematic because it expects them to limit and restrict their ways of treating and healing conditions.

The key findings reveal that biomedical practitioners and traditional healers are at one about preventative measures for *amafufunyana* being a common procedure, indeed, a standardised practice. However, standardisation is complex because it requires a certain protocol and procedure to be followed (Kriznik, Lamé, & Dixon-Woods, 2019).

From the findings on preventing *amafufunyana*, it is evident that *amafufunyana* can be prevented by both biomedical practitioners and African traditional healers. Biomedical practitioners have a standardised way of preventing *amafufunyana* – supportive educational awareness campaigns. Even though they are a heterogenous group, African traditional healers also have their standardised way of preventing *amafufunyana* – the 'ukuqiniswa' ritual.

The study's findings suggest that biomedical practitioners and traditional healers cannot operate in an all-in-one approach because of their different contextual interpretations of *amafufunyana*. The argument surrounding standardised practice is that it suggests that integration is not feasible in this context because procedures must be systemised (Kriznik et al., 2019). These concerns are normally side-lined and ignored in the discourse on medical integration (Scheid & MacPherson, 2011).

Standardised practices are embedded in medical integration and their challenges are plentiful. The narratives from this study have so far revealed the dominance of the biomedical healthcare system, for instance, the reluctance of biomedical practitioners to refer patients to traditional healers. Another identified challenge to parallel collaboration would be the lack of reciprocity by biomedical practitioners. As mentioned in Chapter Four, the underlying challenge is that traditional healers in this study had complained that biomedical practitioners are reluctant of transferring and referring patients to them. It is also doubtful that traditional healers would conform to the standards that are understood by biomedical practitioners and vice versa.

A root cause of the lack of integration can be traced to training. Traditional knowledge and perspectives are not incorporated in the health science curriculum and biomedical knowledge is not being incorporated by traditional healers in their initiation processes (Moeta, Mogale, Mgolozeli, Moagi, & Bhana, 2019; Mokgobi, 2013). Another critical shortcoming is that, although the South African government supports the idea of

integrated healthcare, no policies appear to have been implemented (Mothibe & Sibanda, 2019).

Most studies regarding medical integration indicate that knowledge exchange is lacking, especially in the case of medical schools which have not fully incorporated African traditional knowledge and perspectives into their curricula. This, of course, indicates that the majority of medical schools and traditional healing initiations have not been integrated (Chitindingu, George, & Gow, 2014; Keikelame & Swartz, 2015; Moeta et al., 2019). Within this aspect is the context of transformation. Transformation arises from the anticipated challenges that are identified by African traditional healers and biomedical practitioners. Transformation focuses on cultural inclusivity as a starting point for the integration process (Bodeker, 2001; Mokgobi, 2013).

As biomedical practitioners and traditional healers cannot operate in an all-in-one package, standardised practices will have to be maintained in their respective settings. The model of collaboration of Campbell-Hall et al. (2010) was based on cooperation between traditional healers and biomedical practitioners. Similarly, in this study biomedical practitioners and traditional healers opted to work together on a case-to-case basis. In parallel cooperation, negotiation on how collaboration in light of how each system views illness is needed. The next section considers collaboration in terms of the workable relationship between biomedical practitioners and traditional healers.

5.6 Collaboration

This section shows how traditional healers and biomedical practitioners perceive 'working together' to treat *amafufunyana*. Their suggestion of parallel cooperation is a type of medical collaboration. Way, Jones and Busing (2000) as cited in Boon et al. (2009, p. 721) refer to collaboration as "an inter-professional process for communication and decision-making that enables the separate and shared knowledge and skills of health care providers to synergistically influence the client/patient care provided".

Ideally, medical integration would require collaboration to facilitate an effective standardised practice in healthcare (Boon et al., 2009; Dawda, 2019). Hence, as suggested by the study's findings, this section argues that medical integration is not necessarily a pre-condition for medical collaboration.

In this study, the notion of parallel cooperation between traditional healers and biomedical practitioners seems to be workable. A mutual referral system suggests that collaboration can exist without the implementation of integration. Traditional healers and biomedical practitioners' views on conditional ways of working together within a parallel system converge. In this approach, traditional healers have opted to be autonomous in their practice but accommodate biomedical practitioners' views to 'work together'. This further extends Maqalika's (2020) suggestion that collaboration seems ideal in reconciling traditional healers and biomedical practitioners regarding mental health problems. Although Maqalika's (2020) suggestion was not explicit on the type of collaboration, it mentions that traditional healers and mental health practitioners need to learn from one another to manage psychosis.

Parallel cooperation is a way to preserve power and autonomy since medical integration has not been adopted into the mainstream (Dawda, 2019). From the literature and in a South African context, it is evident that medical integration is a short-term collaborative project and, hence, difficulties in resolving its challenges are experienced (Moshabela et al., 2016). Similarly, in the context of Hlabisa, not many efforts to integrate traditional healers and biomedical practitioners medically have been made. For instance, two of the five African traditional healers indicated working with private medical doctors, however, the relationship was not reciprocal. Moshabela et al. (2016) observe a similar pattern in the issue of collaboration in that the relationship is normally one-sided and favours biomedical practitioners.

The study's findings on collaboration are supported by the suggestion of Campbell-Hall et al. (2010) for traditional healers and biomedical practitioners to share patients – a form of cooperation. This is based on the understanding that these two healing practices would reconcile their differences regarding collaboration when treating *amafufunyana*. For this reason, it correlates with one of the basic ideals of collaboration – embracing different practices in healthcare (Boon et al., 2009).

The key findings revealed that all the traditional healers in this study had indicated their willingness to collaborate as opposed to the biomedical practitioners. Van de Watt et al. (2020) concur that traditional healers are more reciprocal than biomedical practitioners in the pursuit of collaborative practice. Tensions and mistrust on the part

of biomedical practitioners have clearly not subsided. Previous studies have indicated that the tensions date back to when traditional healers were forbidden to practice under the Apartheid government (Campbell-Hall et al., 2010; Moshabela et al., 2016; Van de Watt et al., 2020; Wreford, 2005).

The key features which seem to bind collaborative relations are cooperation and reciprocity (Campbell-Hall et al., 2010; Wreford, 2005). This was confirmed by the analysis of the biomedical practitioners' views on collaboration with the African traditional healers and vice versa. Campbell-Hall et al. (2010) and Ensink and Robertson (1996) called for reciprocal collaboration between health care practitioners and traditional healers on psychological issues. In response to their call, this study advocates support for parallel cooperation.

5.7 Conclusion

This chapter discussed the study's findings on the identified aspects of medical integration and argued that parallel cooperation is a feasible option for bridging the cultural gaps between biomedical practitioners and African traditional healers. The key identified aspects were the contextual meaning of illnesses, regulatory challenges to medical integration, the role of government in terms of financial and structural support, standardised practice and collaboration. In essence, these elements shaped this chapter and reviewed the challenges to medical integration in a South African context. The following chapter provides the conclusion and recommendations of the study.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Overview of the study

This study explored the perceptions of African traditional healers and biomedical practitioners on *amafufunyana* by focusing on healing, prevention, and the possibilities for collaboration. *Amafufunyana* is one of the conditions that differ in its conceptualisation from time to time and its conceptualisation remains contested. The research problem is centred around the underlying issue of medical integration being misunderstood and unsustainable in the case of short-term collaborative projects (Campbell-Hall et al., 2010; Hlabano, 2013; Maphumulo & Bhengu, 2019).

The aim of this study was framed from the challenges that medical integration poses in a South African context. In so doing, it shifts away from arguments for medical integration and mutual cooperation and suggests parallel cooperation. Moreover, the study's thesis statement affirms that parallel cooperation should be considered as a way of bridging the cultural gaps between biomedical practitioners and traditional healers concerning *amafufunyana*. Therefore, it was important to discuss parallel cooperation alongside medical integration.

The literature review was prompted by the research questions, research objectives and aim of the study and reviewed the perceptions of *amafufunyana* and the debates on medical collaboration, medical pluralism and medical integration. The literature illustrates the different perceptions of *amafufunyana* and how the Western psychiatric paradigm changes those perceptions. The indeterminate nature of the condition of *amafufunyana* is evident in the ongoing medical discourse on how various healing systems interpret illnesses differently. The study's findings used some of these contextual meanings of illnesses to argue for parallel cooperation to bridge the cultural gaps between traditional healers and biomedical practitioners in the treatment of *amafufunyana*.

In the context of *amafufunyana,* medical pluralism and medical integration seem to be complex. Medical integration is dependent on the nature of health conditions. Thus,

these concepts help shape the argument for parallel cooperation as an alternative to medical integration.

The use of the qualitative approach and telephonic interviews as the means of data collection in the study was described. This study used snowball sampling to locate participants and data was analysed using Braun and Clarke's (2006) thematic analysis model. The findings from the data produced ten themes: mental illness, various causes, psychotherapy and anti-psychotics, supportive awareness campaigns, parallel collaboration, evil spiritual possession, witchcraft, 'ukushunqiselwa' and prayer, 'ukuqiniswa' ritual and partnership.

6.2 Conclusions

In navigating the study's thesis statement, this chapter determines whether the research questions were answered and if the research aim and objectives were met. The main research question is the following:

1. What are the perceptions of African traditional healers and biomedical practitioners on healing and prevention and the possibilities of mutual collaboration on *amafufunyana* in Hlabisa?

The sub-questions were:

2. How do African traditional healers and biomedical practitioners understand *amafufunyana*?
3. In what ways is the condition of *amafufunyana* treated?
4. How can African traditional healers and biomedical practitioners identify ways of collaboration in the treatment of *amafufunyana*?

In concluding this report, the key findings of the study will be outlined and how this study has fulfilled the following four research objectives will be revealed:

1. To describe how biomedical practitioners and African traditional healers interpret the condition of *amafufunyana*.
2. To explore how African traditional healers and biomedical practitioners explain the causes of *amafufunyana*.
3. To compare the methods used by biomedical practitioners and African traditional healers to prevent *amafufunyana*.

4. To compare if African traditional healers and biomedical practitioners have an interest in collaborating on the treatment of *amafufunyana*.

Evidence that these research objectives were fulfilled is found in the following key findings of this study. The key findings on the interpretation of *amafufunyana* by traditional healers and biomedical practitioners were that biomedical practitioners interpret *amafufunyana* as a type of mental illness/disorder that results from various causes such as stress, depression, biological and environmental factors and witchcraft, while traditional healers understand *amafufunyana* as an evil spirit possession caused by witchcraft. The findings from this study suggest the improbability of developing a standardised interpretation of *amafufunyana* because biomedical practitioners believe that any form of spirit possession is a major source of mental illness, while traditional healers maintain that *amafufunyana* is just evil spirit possession.

An interesting factor is that traditional healers identify forms of *amafufunyana*, namely, silent and violent *amafufunyana*. Observable symptoms led to this identification. For instance, in silent *amafufunyana,* the victim experiences some sort of social withdrawal, tiredness and crying, while the violent form of *amafufunyana* manifests as a person speaking in a foreign language and being aggressive.

The findings also revealed how the condition of amafufunyana is treated*.* Biomedical practitioners seem to focus on drug medication with inclusive psychotherapy and hypnosis. In contrast, the ways traditional healers treat *amafufunyana* include using techniques such as prayer, bathing and 'ukushunqisela' (smoke inhalation) in conjunction with medicinal herbs. It is worth noting that, depending on the severity of symptoms, both healing paradigms treat this condition differently. The different ways of treating *amafufunyana* contribute to the regulatory challenges to medical integration, specifically as far as the African traditional healing system is concerned.

From the key findings on the prevention of *amafufunyana*, it is evident that *amafufunyana* can be prevented by both biomedical practitioners and African traditional healers. Biomedical practitioners have a standardised way of preventing *amafufunyana* – supportive educational awareness campaigns. African traditional healers also have their standardised way of preventing *amafufunyana* – the 'ukuqiniswa' ritual. The study's findings suggest that biomedical practitioners and

traditional healers cannot operate in an all-in-one approach because of their differing contextual interpretations of *amafufunyana*.

The key findings regarding the possibilities of collaboration among biomedical and traditional healers indicate a conditional willingness to work together. However, biomedical practitioners seek parallel cooperation and traditional healers seek a partnership. Both healing systems raised concerns that their different belief systems posed challenges to working together. Other challenges that were raised were the lack of reciprocity in terms of the biomedical practitioners' referral of patients and the late referral of patients by traditional healers.

The above key findings are evident in the debates surrounding medical integration versus parallel cooperation as attempts to bridge the cultural gaps between biomedical practitioners and traditional healers. Five aspects (contextual meaning of illnesses, regulatory challenges to medical integration, the role of government in providing supportive structures, standardised practices, and collaboration) from medical integration literature were merged with the study's findings. Based on the findings of this study, the thesis statement that parallel cooperation should be considered as a way of bridging the cultural gaps between traditional healers and biomedical practitioners in treating *amafufunyana* is affirmed.

6.3 Recommendations

The recommendations of the study are based on the literature review in conjunction with the study's findings. A replication of this study with a larger sample, in other regions of the country and specifically focusing on the types and names of medications used in treatments will add more literature to understanding *amafufunyana* in different contexts.

The second recommendation is of a need for an open dialogue through a strategic communication towards possibilities of integration. This nuanced approach would be beneficial because of the need to incorporate traditional healers in the national healthcare system.

The third recommendation is that traditional healers implement new strategies to regulate their medicine to ensure its effective and safe use and to align it with

governmental health guidelines. This recommendation might address the issue of bogus traditional healers by strengthening the traditional healing system from within (Moshabela et al., 2016).

The fourth recommendation lends from the studies of Keikelame and Swartz (2015) and Mokgobi (2013) and considers the possibility of the psychiatric and traditional models being culturally inclusive. This cultural inclusivity would address the knowledge gaps between traditional healers and biomedical practitioners. Parallel cooperation through cultural inclusion will help to promote cultural literacy and provide an understanding of other conceptualisations of mental conditions (Keikelame & Swartz, 2015). This implies that a cross-cultural approach has to be employed by both healing systems.

Lastly, a more reciprocal relationship needs to be established. The government must provide supportive structures for medical collaboration by providing a clear policy and guidelines for its implementation (Mothibe & Sibanda, 2019). This will firmly establish successful parallel cooperation (Campbell-Hall et al., 2010). This researcher unequivocally supports the view of Campbell-Hall et al. (2010) that the starting point for an integrated healthcare system requires assistance from the government and external institutions to facilitate the process.

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Appendices

Appendix A: Interview schedule

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Faculty of Humanities
School of Social Science
Department of Sociology
East Campus, Johannesburg, Gauteng, South Africa
Cell no: 0827554971
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---

Name of interviewee: _____

Date: _____ time: _____

Demographic information: age: ___ gender: ___ designation: _____ home language: _____

Section A: The perceptions of *amafufunyana*

1) What is your understanding of *amafufunyana*?

_____

_____

_____

2) To what extent do you believe in that definition?

_____

_____

_____

3) Have you seen a person with *amafufunyana*?

_____

_____

_____

4) Mention the different forms of *amafufunyana* you know

_____

_____

_____

5) What do you conceive to be the sign(s) of *amafufunyana*?

_____

_____

_____

6) State the cause(s) of *amafufunyana*

_____

_____

_____

Section B: Preferred methods of healing and cure

7) How long have you been practising as a traditional healer/medical practitioner?

_____

_____

_____

8) What are the methods of healing and cure do you use for *amafufunyana*?

_____

_____

_____

9) Is this the common method you apply in the hospitals or Is it a common method that every traditional healer applies?

_____

_____

_____

10) How does the form of healing method work?

_____

_____

_____

11) How can you tell that one has been healed from *amafufunyana*?

_____

_____

_____

12) Do patients come on their own or they are being referred?

_____

_____

_____

13) Who refers them?

_____

_____

_____

14) Why?

_____

_____

_____

15) What are the possible measures to prevent the occurrence of *amafufunyana*?

_____

_____

_____

16) Do those measures help prevent the condition?

_____

_____

_____

Section C: Possibilities of mutual collaboration

17) Do you work with practitioners or/traditional healers?

_____

_____

_____

18) If Yes, how do you work with them?

_____

_____

_____

19) What are the advantages of working with them?

_____

_____

_____

20) What are the disadvantages of working with them?

_____

_____

_____

21) If No, why?

_____

_____

_____

22) Would you like to work with them?

_____

_____

_____

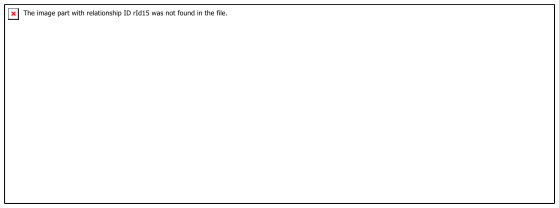
23) If Yes, what challenges do you foresee?

_____

_____

_____

Appendix B: Consent form



Title of project: The perceptions of African traditional healers and biomedical practitioners towards *amafufunyana*: healing, prevention, and possibilities of mutual collaboration in Hlabisa (KwaZulu-Natal).

Name of researcher: Simangele Sithole

I ……. agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

Please circle the relevant options below.

I agree that my participation will remain anonymous YES NO

I agree that the researcher may use anonymous quotes in his / her research report YES NO

I agree that the interview may be audio recorded YES NO

I agree that the information I provide may be used anonymously for academic reasons after this project is completed, subject to their own ethics approval. YES NO

Signature ……

Name of participant ……

Date ……

Appendix C: Participant information

Faculty of Humanities
School of Social Sciences
Unit of Sociology

Dear Sir/Madam

My name is Simangele Sithole, and I am a Masters student in Social Sciences at the University of the Witwatersrand, Johannesburg. As part of my studies, I must undertake a research project, and I am exploring the perceptions of African traditional healers and biomedical practitioners towards *amafufunyana*: healing, prevention, and possibilities of mutual collaboration in Hlabisa (KwaZulu-Natal) under the supervision of Dr Rajohane Matshedisho. The aim of this study This study argues for parallel cooperation between traditional healers and biomedical practitioners. In so doing, it shifts away from arguments for medical integration and mutual cooperation and suggests parallel cooperation on the condition of *amafufunyana* in a South African context.

As part of this project, I would like to invite you to take part in an interview. This activity will involve telephonic interviews and will take approximately 30 minutes. With your permission, I would also like to audio record the interview using a cell phone's internal recording option.

There will be no personal costs to you if you participate in this project, you will not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to. The interview will be confidential, and any information you provide to me will be kept safely on a password-protected computer. I will be using a pseudonym (false name) to represent your participation in my final research report. If you experience any distress

or discomfort at any point in this process, we will stop the interview or resume another time.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0) 11 717 1408, email hrec-medical.researchoffice@wits.ac.za

Yours Sincerely
Simangele Sithole

Researcher:
Simangele Sithole, 2288873@students.wits.ac.za

Supervisor:

Dr Rajohane Matshedisho, Rajohane.matshedisho@wits.ac.za , 0117174434

Appendix D: Ethical clearance certificate

UNIVERSITY OF THE WITWATERSRAND JOHANNESBURG

SOCIOLOGY AND DEVELOPMENT STUDIES ETHICS COMMITTEE (School of Social Sciences)

CONSTITUTED UNDER THE UNIVERSITY HUMAN RESEARCH ETHICS COMMITTEE (NON-MEDICAL)

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: SOCL-2020-08**
PROJECT TITLE	The perceptions of African traditional healers and biomedical practitioners towards amafufunyana: Healing, prevention and posibilities of mutual collaboration.
INVESTIGATOR	Ms. Simangele Sithole
SCHOOL/DEPARTMENT OF INVESTIGATOR	Sociology
DATE CONSIDERED	17 July 2020
DECISION OF THE COMMITTEE	Approved
RISK LEVEL	MINIMAL RISK
EXPIRY DATE	17 July 2023

ISSUE DATE OF CERTIFICATE 28 July 2020 **CHAIRPERSON** _____ (Professor Srila Roy)

cc: Supervisor: Dr Rajohane Matshedisho

DECLARATION OF INVESTIGATOR

To be completed in duplicate and **ONE COPY** returned to the Chairperson of the Department ethics committee.

I fully understand the conditions under which I am are authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee.

S S Sithole

Signature

30 / 07 / 2020

Date

PLEASE QUOTE THE PROTOCOL NUMBER ON ALL ENQUIRIES

Appendix E: Editing Certificate

LET'S EDIT

EDITING CERTIFICATE

09 November 2021

TO WHOM IT MAY CONCERN

DECLARATION: Editing of Research Report

This is to certify that the research report entitled **"THE PERCEPTIONS OF AFRICAN TRADITIONAL HEALERS AND BIOMEDICAL PRACTITIONERS TOWARDS AMAFUFUNYANA: HEALING, PREVENTION AND POSSIBILITIES OF MUTUAL COLLABORATION IN HLABISA (KWAZULU-NATAL)"** submitted by **Simangele Senamile Sithole** was edited for English language, grammar, punctuation, and spelling by the undersigned. Editing also included addressing the layout and formatting of the document.

The editor will not be held accountable for any later additions or changes to the document that were not edited by the editor, nor if the client rejects/ignores any of the changes, suggestions or queries, which he/she is free to do. The editor can also not be held responsible for errors in the content of the document or whether or not the client passes or fails. It is the client's responsibility to review the edited document before submitting it for evaluation.

Name of Editor: Shirley Wilson

Qualification: Bachelor of Arts (in Education)

Signature: 

Let's Edit is a Level 1 EME B-BBEE Contributor (Procurement Recognition Level = 135%)

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Tel No.: **012 433 6584,** Fax No.: **086 267 2164** and Email Address: **editor@letsedit.co.za**