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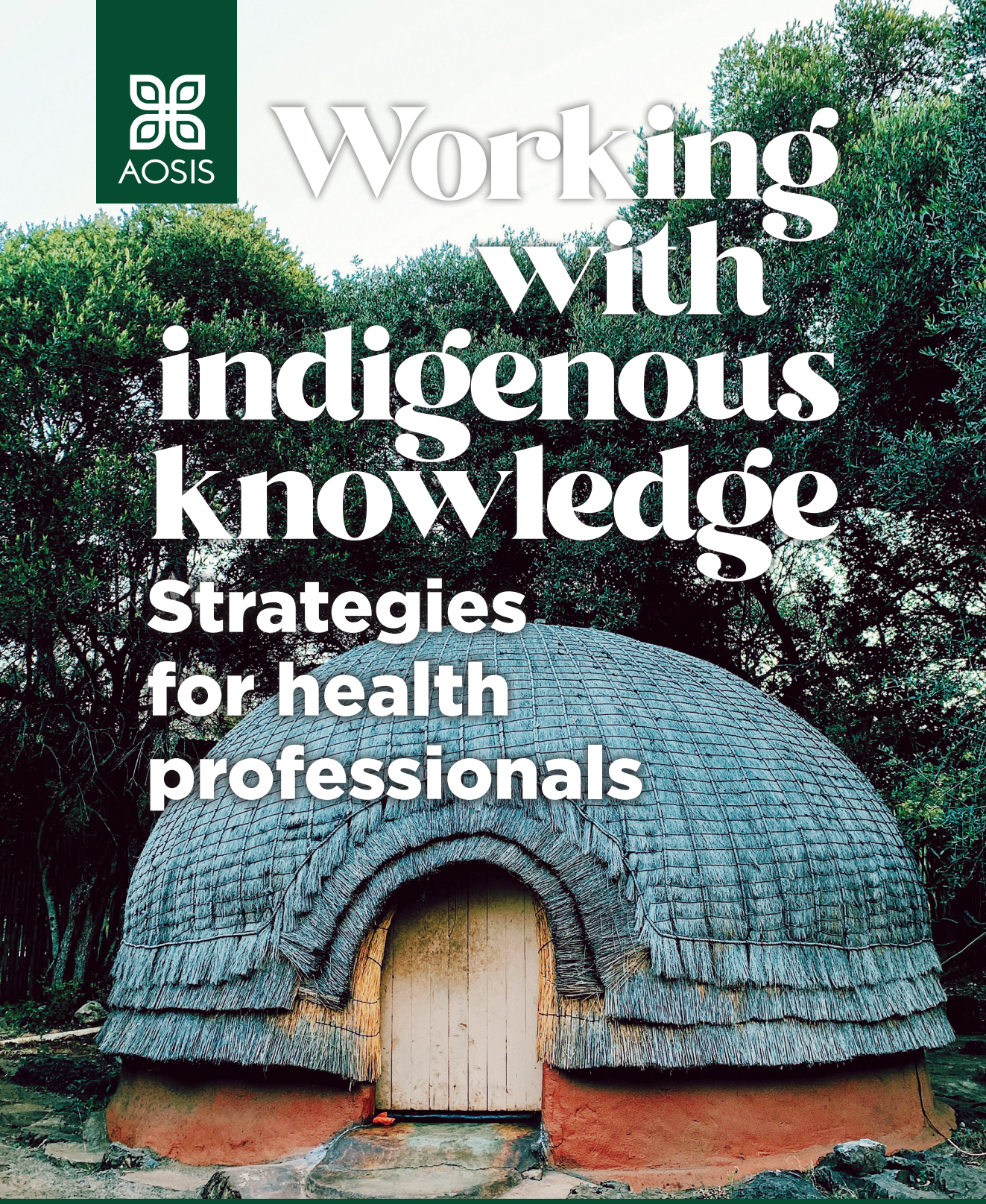
Working with indigenous knowledge

Strategies for health professionals



Edited by
Fhumulani Mavis Mulaudzi & Rachel Lebese

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Peer review declaration

The publisher (AOSIS) endorses the South African 'National Scholarly Book Publishers Forum Best Practice for Peer Review of Scholarly Books'. The manuscript underwent an evaluation to compare the level of originality with other published works and was subjected to rigorous two-step peer review before publication, with the identities of the reviewers not revealed to the editor(s) or author(s). The reviewers were independent of the publisher, editor(s) and author(s). The publisher shared feedback on the similarity report and the reviewers' inputs with the manuscript's editor(s) or author(s) to improve the manuscript. Where the reviewers recommended revision and improvements, editor(s) or author(s) responded adequately to such recommendations. The reviewers commented positively on the scholarly merits of the manuscript and recommended that the book be published.

Research justification

The book emanates from the continuous collaborative research efforts that the current NRF-funded Research Chair for Albertina Sisulu on the Ubuntu Model of Nursing Science has established for the past decade. The authors are from different disciplines, pursuing transdisciplinary research endeavours centred around indigenous knowledge. Other collaborators include traditional health practitioners who are part of the project and were also consulted to verify the information where necessary.

This book represents a scholarly discourse on various topics on indigenous knowledge and health care. Well-researched knowledge, attitudes, practices and cultural beliefs of communities are well-documented in the book. Some of the chapters report the research findings that emanated from the results of original research that emerged from MA and PhD theses. These chapters represent a substantial reworking (more than 50%) of the unpublished theses. Subsequently, new information that emerged was added and citations were provided. The book was also independently peer-reviewed by external experts in the field.

The chapters range from communication discordance between health care professionals and indigenous patients; indigenous practices in health care promotion and disease prevention; child spacing and child birthing practices; the provision of neonatal health care; menopause among females of African descent; sexually transmitted infections; insights on indigenous mental illness treatment; same-sex intimacy, relationships and marriages among African indigenous people; the role of patriarchy and its influences on domestic violence against females and children in Africa; and nutritious edible indigenous vegetables.

The book is designed for use by academics and researchers in this field of health sciences studies. The aim of the book is to assist both local and international scholars in articulating the scholarly discourse on indigenous health care attitudes, practices and experiences. The indigenous lens that was used to generate and disseminate indigenous knowledge in this book will strengthen indigenous scholarship, thus making it accessible to a wider audience. In addition, the information shared in this book will add value to the scholars to assist them with the indigenous knowledge needed to address the sustainable development goals (SDGs) as set by the United Nations Educational, Scientific and Cultural Organization (UNESCO).

The research design and methods used were mainly qualitative in nature. Integrative literature review methods were also used in some of the chapters to articulate the synopsis of what transpires in local communities, comparing and validating the practices and knowledge that are also embedded within other cultures in the African region. Participatory action research methods were also used to generate knowledge that is owned and explained by the communities themselves.

This book is timeous and topical as the discourse on decolonisation of the curriculum is widely debated in the higher education space. The discourse on the scholarship of indigenous knowledge has not been well-articulated in the current health science education milieu. Indigenous knowledge is the tacit local knowledge that stems from the cultural practices of communities. Indigenous knowledge has always been transmitted orally from one generation to another. Indigenous knowledge has been overlooked and undermined for a very long time. The information remains untapped in local communities and is used locally for survival strategies. The scholars who conducted research on which this book is based unearthed a wealth of knowledge which was tacit in nature and translated it into implicit knowledge that can be documented and shared with other scholars globally.

The knowledge will assist health care scholars in benefiting from knowledge, practices and cultural beliefs that will assist them in health care planning, teaching evidence-based practice and further research.

The authors declare that the iThenticate reports of each chapter were submitted to evaluate and resolve the similarity index to avoid plagiarism.

Fhumulani Mavis Mulaudzi, Department of Nursing, Faculty of Health Sciences, University of Pretoria, Pretoria, South Africa.

Rachel T. Lebese, Department of Advanced Nursing Science, Faculty of Health Sciences, University of Venda, Thohoyandou, South Africa.

Contents

Abbreviations and acronyms, figures and tables appearing in the text and notes

List of abbreviations and acronyms

AIDS	acquired immunodeficiency syndrome
AJPHES	*African Journal for Physical Activity and Health Sciences*
ANAC	Association of Nurses in AIDS Care
ATM	African traditional medicines
BA	Bachelor of Arts degree; bachelor's degree
BBA	born before arrival
BCEA	*Basic Conditions of Employment Act 75 of 1997*
CANSA	Cancer Association of South Africa
CRL	*Cultural, Religious and Linguistic*
CSSR	Center for Social Science Research
D&C	dilatation and curettage
DENOSA	Democratic Nursing Organisation of South Africa
DHET	Department of Higher Education and Training
DNA	deoxyribonucleic acid
DoH	Department of Health
DRC	Democratic Republic of the Congo
EPWP	Extended Public Works Programme
ESP	extrasensory perception
FUNDISA	Forum for the University Deans of South Africa
HIV	human immunodeficiency virus
Hons	honours degree
IKH	indigenous knowledge holders
IKS	indigenous knowledge system
IKSP	indigenous knowledge systems and practices
IPV	intimate partner violence
IWT	indigenous wholistic theory
LGBTQI+	lesbian, gay, bisexual, transgender, queer, intersex and seeking
MA	Master of Arts degree; master's degree
NASUWT	National Association of Schoolmasters Union of Females Teachers
NCD	non-communicable diseases
NRF	National Research Foundation
NWU	North-West University

PanSALB	Pan South African Language Board
PhD	Doctor of Philosophy degree; doctoral degree
PMS	premenstrual syndrome
RHAP	Rural Health Advocacy Project
RMC	respectful maternity care
RNA	ribonucleic acid
SACERT	Sustainable Academic Capacity Building for Excellence through the Research and Training
SACNASP	South African Council for Natural Scientific Profession
SARChI	South African Research Chairs Initiative
SDG	sustainable development goal
SSMPA	*Same-Sex Marriage Prohibition Act*
STI	sexually transmitted infection
TB	tuberculosis
TBA	traditional birth attendants
UFS	University of the Free State
UK	United Kingdom
UNDP	United Nations Development Programme
UP	University of Pretoria
WHIL	Water Health in Limpopo
WHO	World Health Organization
ZCC	Zion Christian Church

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Glossary

- ***a rite of passage*:** An event or ceremony practiced within different cultural groups, especially among indigenous African people to mark an important transition in a person's life
- ***ababeletisi*:** Referred to as traditional birth attendants or indigenous midwives in IsiZulu
- ***abakhwetha*:** Initiates
- ***abathandazi*:** Faith healers
- ***amadlodzi*:** A word for the ancestors
- ***amafufunyane/botsenwa/bogafa/kupenga*:** A person who shows signs of mental illness or challenges
- ***amakhosikazi akithi*:** Grandmothers or elderly females who have passed menopause
- ***antioxidants*:** A group of chemical substances that prevent and or repair damage to cells caused by exposure to oxidising agents and smoke normally produced in the body
- ***artemisia*:** Also known as *thiumbeumbe*, it is utilised by African people as a steam inhaler in case one has flu symptoms.
- ***ba thekga bana ba bona*:** Strengthens the infant's resilience from contracting diseases
- ***badimo/vadzimu*:** Ancestors
- ***badimo*:** Ancestors
- ***bana ba ba badimo*:** Children of the gods
- ***Bapedi*:** A tribe that is a subgroup of the Sotho people who live in the northern part of South Africa
- ***bofelo bja lehlapo or kgwedi/ukuyeka ukuya exesheni/u sema vhakegulu*:** Menopause
- ***bogafi/botsenwa/ukuphambana/ukuhlanya/kupenga/vimbuza/onye ala*:** Mental illness
- ***bogatsu*:** Numbness
- ***bohloko bja popelo*:** Pain in the uterus
- ***bohloko/botlhoko*:** Pain
- ***bokonchana*:** Male-male sexual relationships
- ***boloi*:** Relates to witchcraft acts by harming other people targeted
- ***cha motende*:** Male-to-male sexual activity
- ***chingochani*:** Homosexuality
- ***chipindira*:** Failure by the infant to suckle
- ***chukela*:** Diabetes mellitus
- ***death*:** Regarded as a return to spiritual life

- ***demamhandwe*:** A wild herbal plant
- ***dikgaba*:** Harm or heartache
- ***diša*:** Ritual performance and herbal medicine
- ***ditaola*:** Divination bones
- ***divhu (u wela)*:** Literally translated as 'to fall in'. This is a type of sexually transmitted infection that occurs when a male sleeps with a female who had an abortion.
- ***dorobo*:** A type of sexually transmitted infection that is diagnosed symptomatically when a male or female experiences heavy yellowish discharge.
- ***dupa/doepa*:** Protection from evil spirits
- ***dzithai*:** Riddles
- ***Dzithevhula*:** A feast in which traditional beer is spilled during a ceremony used to appease and connect with the ancestors.
- ***e-esma/asthma/isfuba*:** Chest disease
- ***Eucalyptus paniculate*:** Also known as *mubomo*, it is inhaled as steam for the upper respiratory system, like *Artemisia*
- ***fembo*:** A practice by which the traditional healer connects the patient with their ancestors by using the patient's smell as a method of diagnosis.
- ***food security*:** When people at all times have physical, social, and economic access to sufficient, safe and nutritious foods.
- ***food system*:** Described as the process that influences nutrition, food, health, community development, and agriculture.
- ***fufulelwa*:** Hot flushes
- ***functional foods*:** Food products that have a physiological benefit or reduce the risk of chronic disease beyond basic nutritional functions.
- ***gegulu*:** Elderly/senior female
- ***go laola*:** Bone throwing, to diagnose an ill person
- ***go nyalela lapa mosadi*:** Marrying a bride for the family
- ***go phekolwa/u thathuvhiwa*:** Diagnosis
- ***go thekga*:** To protect
- ***gokhonya*:** A type of sexually transmitted infection wherein babies are born with a red mark on the occiput
- ***goni (lekone)*:** An eagle (in this case, it refers to a type of a sexually transmitted infection which is similar to *gokhonya*)
- ***gula*:** Placenta and membranes, known as *ungubo yomtwana* in IsiZulu
- ***hlogoana*:** Small head or sunken anterior fontanelle
- ***huzun*:** Sadness or grief
- ***ibala/rigoni*:** Red marks or rash on the back of a newborn's neck
- ***ibala*:** The same disease as *gokhonya*; however, in this case the disease is named based on the red discolouration that is found on the occiput of the affected baby.

- ***imbeleko/mereko*:** Celebration
- ***indigenous vegetables*:** Vegetables that are locally important for the sustainability of the economy, health and nutrition. They grow spontaneously in the wild or farmland and thrive well under rain-fed conditions and adapt well to harsh environments.
- ***indigenous*:** Originating or occurring naturally in a particular place; native
- ***Initiation*:** Introduces the initiate to communal living, where they are withdrawn from their family to go and live with other initiates in the forests.
- ***injonga*:** Male-to-male sexual relationships or gay males
- ***inkotshane/bokonchana*:** Male-male sexual relationships
- ***inkwili/ungqingili/isitabane/trassie/moffie*:** A gay male
- ***isi mgbaka/isi mmebi/agwu*:** When a person is suffering from this type of mental illness it is said that they are possessed
- ***isifuba*:** Chest disease
- ***isigaba sokuqhala sokubeletha*:** Progress of labour or childbirth
- ***isihlambezo*:** A herbal concoction used to precipitate labour
- ***isiphandla*:** Wristband
- ***isiXhosa*:** Part of the branch of Nguni languages known as Zunda languages, which include isiZulu and isiNdebele. IsiXhosa is mostly spoken in the Eastern Cape and Western Cape provinces of South Africa.
- ***isiZulu*:** A Nguni branch-language spoken in Southern Africa. Speakers primarily live in the KwaZulu-Natal province of South Africa.
- ***ixhwele*:** Herbalist
- ***jeko gadzi*:** Milder type of menstrual pain
- ***kanna/kougoed*:** Something to chew
- ***kgaba*:** Medicine to manage *dikgaba*, postdates and prolonged labour
- ***ku khomba/u imbelwa*:** An activity performed by females where a female child is initiated after puberty.
- ***kubememba/lukala*:** A disease that affects breastfeeding babies, caused by contaminated breast milk if parents engage in sexual intercourse. It is believed that the breast milk would be contaminated by sperm and the baby will suffer from *lukala* (in Tshivenḓa) or *kubememba* (according to Zimbabwean culture). The symptoms resemble that of marasmus or malnutrition.
- ***kufikiria sana*:** Psychological distress
- ***kugura nhowo*:** Cutting of the reed mat
- ***lebitla la mosadi ke bogadi*:** A Tswana proverb that means 'a male is like a monkey; he eats with two hands', implying that married males are allowed to have concubines to satisfy their sexual needs.
- ***leina la bokgekelo*:** Old-age name
- ***lelothoane*:** Sage wood leaves

- ***lethlapo la popelo*:** Cleansing of the uterus
- ***lewa*:** The falling of bones during the diagnostic process
- ***liminality*:** The time when initiates return from the edge, and it is a new role or identity they assume
- ***lobola*:** Bride price
- ***luhlukumezeko olumasikizi (Nguni tribe), thesebediso e fosahetseng (Basotho tribe) and Ilokulo (Yoruba tribe)*:** Direct translations for 'domestic violence'
- ***luselo*:** Large indigenous tray made from reeds
- ***maambele*:** Idiomatic expressions
- ***madi a magolo*:** High blood pressure
- ***maendlelo ya ndzhavuko/imfundiso zesintu*:** Indigenous practices of childbirth
- ***mafa (boswagadi, meriti, mehlala, makgome)*:** A type of sexually transmitted infection that occurs if a male has slept with a widow
- ***mahlayiselo ya Vasungukati*:** Midwifery health care system
- ***makgoma*:** A culturally-bound illness characterised by severe bloating and restlessness
- ***makhuma*:** Subinvolution of the uterus
- ***makondwa/maguechue*:** An indigenous mixture prepared from tree bucks, roots, water and *mahewu* [porridge] which is given to boys at puberty to thicken the semen and improve fertility.
- ***male circumcision*:** Involves surgical removal of the foreskin; however, various initiation teachings accompany the surgery.
- ***malnutrition*:** Refers to the imbalance of cells between the supply of nutrients and energy and the body's demand for them to ensure growth, maintenance, and specific functions.
- ***malwadze a vhasadzi*:** Females's illnesses
- ***malwadze*:** Illness
- ***marabo*:** Known as ancestral bones used by traditional health practitioners to assess, diagnose and treat patients.
- ***mashontsa*:** Mopani worms
- ***matanyola*:** A male engaging in sexual intercourse with another male
- ***mbita*:** Herbal medicine used to protect against evil
- ***medicinal*:** A substance or vegetable that contains healing properties.
- ***meleko*:** Evil spirits and people using muthi
- ***meriti ya batho*:** Presence of unknown people around the infant
- ***mirero*:** Proverbs
- ***mirunzi ya vhathu*:** Evil spirits carried by people
- ***mithuso*:** Ritual performed to protect the neonate from natural and unnatural illnesses, as well as from environmental and external harm

- ***mmereko wa gago wa bosadi o fedile*:** Femalehood came to an end
- ***mmonna ke tshwene o ja ka matsogo a mabedi*:** Another Tswana proverb that means a 'male is like a monkey; he eats with both hands', denoting that married males may have concubines to satisfy their sexual needs.
- ***moeno*:** Totem
- ***mokabe*:** A male who has a swollen scrotum due to sleeping with a female who is going through menopause
- ***molwetši/mulwadze*:** Patient
- ***moqopolla-thupa*:** Cape clover red
- ***moya wa badimo*:** Ancestral spirit
- ***mphephi/motlhatlhaila*:** Old female's bush
- ***mteto*:** A same-sex marriage ceremony
- ***muthi*:** Herbal medication
- ***muthi*:** Traditional herbs
- ***n'ombe*:** High blood pressure in Xitsonga
- ***ndumeliso/ulosha*:** Greeting
- ***nganga*:** Traditional health care practitioner
- ***ngoma*:** Anterior fontanelle
- ***ngwana ke wa dikgomo*:** 'The child belongs to the one who paid the bride price'
- ***ngwana o nyaka leina*:** Correct naming of the child
- ***ngwana wa badimo*:** Ancestors' child
- ***ngwetši ya lapa*:** A female married to another female as a family bride
- ***nsivela mavabyi*:** Refers to health care promotion
- ***ntswu*:** Mixture of boiled water and indigenous herbs that are used to treat tshilala
- ***obusasi tibunisa'mara*:** An African proverb that translates as 'pain does not kill'
- ***phytochemicals*:** Chemical substances found in plants that may benefit the health of human beings
- ***puberty*:** Regarded as a passage from childhood to adulthood, celebrated according to the different African cultural groups
- ***rigoni*:** Red spot or mark on the occiput of an infant
- ***sangoma/ngaka/selaodi/vhomaine/mungome*:** Traditional healer
- ***separation*:** First step toward something new. Thus, one separates from familiarity and social structures and gradually gets closer to the unknown to learn and acquire new skills.
- ***Sepedi*:** Language spoken by a subgroup of the Sotho people living in the Northern parts (Limpopo province) of South Africa
- ***shoga*:** Homosexual
- ***skesana*:** Female-to-female sexual relationships

- ***stuipdruppels*:** Mixture for effective relief from flatulence, gripes and colic
- ***the nutrition transition*:** Change or shift in dietary consumption and energy expenditure that accompany changes in economic development, lifestyle, urbanisation and demography.
- ***theepe*:** Pigweed/young shoots
- ***thunya/tsunyetsa*:** Pricking pain
- ***thusula, thosola, gcunshula*:** A type of sexually transmitted infection with complications including sores all over the body.
- ***tlhahlo ya semoya*:** Spiritual initiation
- ***tshidongo*:** An eating or feeding bowl
- ***tshikwilimba*:** A disease that develops when a female who is in the menopause stage engages in sexual intercourse with a male who is still virile.
- ***tshilala*:** Neonatal reflux accompanied by abdominal cramps or colic
- ***tshilwana*:** Post-birth abdominal pains
- ***tshimbambaila, Ikhubalo lenja, u reiwa, runyoka*:** A sexually transmitted infection that occurs when a male has had sexual intercourse with a female who is locked
- ***tshipande (nnda)*:** Lice found in the genitals
- ***tshiunza/khongodoli*:** A very light and warm soft porridge with herbal concoctions
- ***tshovela, tshofela, cauliflower*:** A growth that develops on the genital area
- ***u fhahea nowa*** – in Tshivenḓa, literally it means to hang a snake (a uterus in Tshivenḓa is referred to as *nowa* [snake]). An indigenous practice by the VhaVenḓa of mixing the menstrual blood with some herbs and hiding it on the roof of a hut to prevent pregnancy.
- ***u kanda nwana*:** Transmission of infection or bad spirits to the neonate making it to be sick and putting its life at risk
- ***u lima masimu*:** Activity completed by both males and females which includes planting and ploughing maize meal
- ***u malela musadzi muta*:** Marrying a bride for the family
- ***u tohola mavhele*:** Also known as grinding maize meal is another activity that promotes and prevents diseases performed by females
- ***ubuntu*:** Humaneness
- ***ukhakhayi*:** Fontanelle
- ***ukubeletha*:** Labour or childbirth
- ***ukufemba/nyakišiša*:** Smelling a person's problems or other issues
- ***ukuhlamba*:** To cleanse the ceremonially for protection
- ***ukukhulelwa/nyimba*:** Pregnancy
- ***ukuthwasa/kwetfwasa/gothwasa*:** An initiation process undertaken to become a traditional health care practitioner

- ***ulwaluko*:** The process of initiation into manhood
- ***umoya*:** Spiritual energy
- ***VaTsonga*:** Mostly found living in the Limpopo and Mpumalanga provinces in South Africa, as well as in Mozambique
- ***vhasadzi*:** Females
- ***VhaVenḓa*:** South African people mostly found living in the Limpopo province, near the Zimbabwean border
- ***vutsedyani*:** Afterbirth
- ***vutswedyani*:** Postnatal period
- ***Western diets*:** Those diets that contain a high amount of saturated fats, refined carbohydrates and salt.
- ***xikuru-nyimba*:** Bulging stomach
- ***xirhakarhani*:** Indigenous analgesic used to ease labour and prepare for labour
- ***Xitsonga*:** Tsonga/Shangaan
- ***ye ba e binago*:** Venerate, uplifting the spirit of belonging, proclaiming dominance
- ***zwi a ila*:** Things that are not supposed to be done; when done, result in curses

Notes on contributors

Azwihangwisi H. Mavhandu-Mudzusi
Department of Health Studies,
College of Human Sciences,
University of South Africa,
Pretoria, South Africa
Email: mmudza@unisa.ac.za
ORCID: https://orcid.org/0000-0002-6916-8472

Azwihangwisi H. Mavhandu-Mudzusi is an NRF C-rated researcher working at the University of South Africa (Unisa). She holds a PhD in Public Management, a MA in Nursing, an Hons in Psychology and Nursing. Her main passion is advocacy for marginalised groups, especially people living with HIV and AIDS and lesbian, gay, bisexual, transgender, queer, intersex and seeking (LGBTQI+) individuals in higher education institutions and rural communities. She has published several articles in national and international journals. She is the recipient of 2017 Women in Science Award (Distinguished Woman Scientist).

Fhumulani M. Mulaudzi
Department of Nursing,
Faculty of Health Sciences,
University of Pretoria,
Pretoria, South Africa
Email: mavis.mulaudzi@up.ac.za
ORCID: https://orcid.org/0000-0001-5144-0266

Fhumulani M. Mulaudzi is the South African Research Chair in Ubuntu Community Model in Nursing and an NRF C-rated researcher at the University of Pretoria. Prior to her appointment with the South African Research Chairs Initiative (SARChI), she was the Head of the Department of Nursing Science for ten years and chair of the School of Health Sciences. She holds a BCur Nursing degree, BCur Hons, MA Nursing, PhD in Literature and Philosophy in Nursing (Unisa), a postgraduate diploma in International Health Research Ethics (University of Cape Town [UCT]) and an advanced diploma in Health Management. Her research interest lies in indigenous knowledge, human rights and ethics. She was the editor-in-chief of the *Curationis* journal. She has served in many leadership positions in different organizations. She is currently the president of the Global Nurses and Midwives Rotary Club and the first deputy president of the Democratic Nursing Organisation of South Africa (DENOSA). She has published widely in accredited journals.

Jeanette M. Sebaeng
School of Nursing,
Faculty of Health Sciences, University of the Free State,
Bloemfontein, South Africa
Email: SebaengJM@ufs.ac.za
ORCID: https://orcid.org/0000-0002-6495-9654

Jeanette M. Sebaeng is a senior lecturer and the head of school at the University of the Free State (UFS). Before joining the UFS, she served as an undergraduate nursing programme manager at North-West University (NWU). Her research focuses on clinical forensic nursing, nursing education and general nursing science. Sebaeng served in several leadership positions and is currently an executive committee member of the South African Forensic Nursing Association and a member of the research portfolio of the Forum for the University Deans of South Africa (FUNDISA).

Khathutshelo G. Simane-Netshisaulu
Department of Advanced Nursing Science,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa
Email: khathu.netshisaulu@univen.ac.za
ORCID: https://orcid.org/0000-0002-2897-7134

Khathutshelo G. Simane-Netshisaulu is a senior lecturer in the Department of Advanced Nursing Science, University of Venda. Her research interest lies in maternal and reproductive health care as well as midwifery education and training. She has previously served in many leadership positions at different institutions. She serves as The Head of Students' Clinical Learning for BCurp, BNurs and diploma students at the University of Venda. She is an active researcher who continues to publish in accredited journals.

Lindelani F. Mushaphi
Department of Nutrition,
Faculty of Health Sciences,
University of Venda,
Thohoyandou, South Africa
Email:lindelani.mushaphi@univen.ac.za
ORCID: https://orcid.org/0000-0001-8148-6118

Lindelani F. Mushaphi is working as a senior lecturer and head of the Department of Nutrition in the Faculty of Health Sciences, University of Venda, South Africa. She obtained MA in Nutrition from the University of Limpopo (which was the University of the North). She graduated with a PhD in Nutrition from UFS in 2012. In August 2006, she won the Women in Science Award from the Department of Science and Technology for PhD studies. She was also awarded the NRF Thuthukha Grant to fund her PhD studies. In 2014, she was awarded a postdoctoral fellowship with Water Health in Limpopo (WHIL) Innovation with the University of Venda and the University of Virginia.

Her research area is micronutrients, non-communicable diseases, maternal and child nutrition, as well as the indigenous food system. She supervised 50 undergraduate and sixteen postgraduate research projects to completion (14 MAs and two PhDs). She has published 21 peer-reviewed articles. She is currently participating in the Future Professor's Programme at Stellenbosch University (SUN).

Lufuno Makhado
Department of Public Health,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa
Email: lufuno.makhado@univen.ac.za
ORCID: https://orcid.org/0000-0003-1689-9308

Lufuno Makhado is an associate professor in the Department of Public Health and the deputy dean: research and postgraduate studies within the Faculty of Health Sciences in the University of Venda. He is the project leader of the GladAfrica Epilepsy Research project and the primary South African investigator in Study VIII: The Impact of the COVID-19 Pandemic on People with HIV (multi-country site study). He became an NRF-rated researcher in 2021. He has served in many structures for different organizations. He is a member of the Association of Nurses in AIDS Care (ANAC) and the International Nursing Network for HIV and AIDS Research. He is an expert in epidemiology and biostatistics and quantitative research. He is an editorial board member for *Curationis* and *Health SA Gesondheid – Journal of Interdisciplinary Health Sciences* journals (national) and BMC Nursing and INQUIRY: *The Journal of Health Care Organization Provision and Financing* (international). He has also been a reviewer for local, regional and international journals. He has published widely in national and international peer-reviewed journals.

Madimetja Magoro
Tompi Seleka College of Agriculture,
Agriculture Extension, Economics and Partnerships,
Marble Hall, South Africa
Email: magorom@agric.limpopo.gov.za
ORCID: https://orcid.org/0000-0001-7680-6498

Madimetja Magoro is an indigenous knowledge system researcher and head of the Department of Agriculture Extension and Partnerships at Tompi Seleka College of Agriculture. He is also a long-serving member of the National Steering Committee of the United Nations Development Programme (UNDP). He is a registered Professional Scientist with South African Council for Natural Scientific Profession (SACNASP). He is a member of the South African Society for Agriculture Extension. His research interest lies in indigenous knowledge, human ecology, and agronomy. He has reviewed papers for publication in various journals. He has published widely in accredited journals.

Masetopana E. Ramaube
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa
Email: lisbertmr@gmail.com
ORCID: Not available

Masetopana E. Ramaube is a professional nurse who is registered as a primary health care nursing practitioner, occupational health care nurse and psychiatric nurse with vast experience in community health care nursing and based around the City of Tshwane for many years. She obtained her MA in Nursing from the University of Pretoria in 2018. Her research interest lies in ethnography and indigenous health care.

Maurine R. Musie
Department of Nursing Sciences,
Faculty of Health Care Sciences, University of Pretoria,
Pretoria, South Africa
Email: maurine.musie@up.ac.za
ORCID: https://orcid.org/0000-0002-9572-6319

Maurine R. Musie is an advanced midwifery specialist and lecturer in the University of Pretoria's (UP) Nursing Department. She was completing her PhD studies. Her research interest is in the promotion of respectful maternity care (RMC) and the integration of traditional health care into midwifery practice. In 2015, she became the first African student to obtain a cum laude BA in Nursing Sciences. She is a representative from South Africa for the Nursing Now global challenge. She has supervised several MA students to completion. She is part of the leading team of the maternal and child ubuntu community model sub-unit. She was bestowed with the Emergent Research Excellence Award at UP in 2021. She has published widely in accredited journals internationally and nationally.

Melitah M. Rasweswe
Department of Nursing,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa
Email: rasweswemelitah@gmail.com
ORCID: https://orcid.org/0000-0002-5077-5440

Melitah M. Rasweswe is an associate professor at the University of Limpopo, South Africa. Prior to this appointment, she worked as a senior lecturer for Community Nursing Science and Operating Theatre Nursing at UP. Her research interest areas are transdisciplinary and female health care with a broad focus on indigenous knowledge, leadership, marginalisation and vulnerability. She is also interested in using indigenous research methods that contribute to the decolonisation of the research process in previously marginalised communities. She has served as a chair for community engagement, a guardian lecturer and a clinical coordinator at UP. She also served as a CETU task team member at the

National Department of Health, Gauteng Province. She is a board member for the Lifebox Foundation, improving surgical safety. She has published papers widely in reputed, refereed journals.

Mercy T. Mulaudzi
Department of Psychology,
Faculty of Health Science, University of Venda,
Thohoyandou, South Africa
Email: mercy.mulaudzi@univen.ac.za
ORCID: https://orcid.org/0000-0003-2941-4728

Mercy T. Mulaudzi is a professor of Psychology and the acting executive dean of the Faculty of Health Sciences at the University of Venda. Prior to her appointment as acting executive dean, Mulaudzi was the head of the Department of Psychology and was also the dean of the *then* School of Health Sciences at the same university. Her research interests lie in mental health care, indigenous knowledge systems and communicable and non-communicable diseases. She has supervised 15 MA and six PhD students. She serves in many leadership positions. She is currently the principal investigator in a collaborative research project between the University of Venda and Annamalai University in India. Mulaudzi was the recipient of two international scholarships. Mudlauzi received the Michael Moody Fitness Scholarship, where she spent four months at Michigan University, Ann Arbor, and attended different research methodology courses. She completed her postdoctoral MSc in Epidemiology at Columbia University in New York as part of the UWA Fogarty Foundation Scholarship Programme. She has published widely in national and international journals, which are accredited by the South African Department of Higher Education and Training (DHET). She continues to review articles for national and international journals and abstracts for national and international conferences.

Miriam Moagi
Department of Nursing,
Faculty of Health Care Sciences,
School of Nursing Science, North-West University,
Mafikeng, South Africa
Email: 12609439@nwu.ac.za
ORCID: https://orcid.org/0000-0001-7291-1418

Miriam Moagi is a research professor in the School of Nursing Science, NWU, Mahikeng campus. Her research interest is in mental health care, substance use and abuse, program development, students/adolescents' health care and homeless mentally ill people. In 2015, she was involved in the National Project, Localizing National Drug Master Plan within the City of Tshwane, UP, with the Health and Social Development Department. In 2017, she was awarded a scholarship under the Tirisano Project Scholar award and visited the University of California. She is currently a mentor for Sustainable Academic Capacity Building for Excellence through the Research and Training Programme

(SACERT) at the University of California. From 2013 to 2022, she supervised 13 MA and two PhD candidates to completion. She co-authored seventeen articles. She is a reviewer of articles for both national and international journals. She has been a member of the NWU Research Ethics Committee since 2021. She served as general secretary for Chi-Xi at Large Chapter and was a board member from 2019 to 2021.

Ellen M. Mathapo-Thobakgale
Department of Nursing,
Faculty of Health Care Sciences,
School of Health Care Sciences, University of Limpopo,
Turfloop, South Africa
Email: mokgobola.thobakgale@ul.ac.za
ORCID: https://orcid.org/0000-0002-3717-005X

Ellen M. Mathapo-Thobakgale is a South African researcher and coordinator in the clinical skills laboratory at the University of Limpopo. Prior to her appointment as the clinical skills laboratory coordinator, Mathapo-Thobakgale was the clinical skills facilitator and lecturer for psychiatric nursing science, nursing education and community nursing sciences in the Nursing Department of the School of Health Care Sciences. Her research interest lies in mental health care nursing, indigenous knowledge systems and nursing education. She is an emerging author in mental health care nursing and indigenous knowledge systems and a reviewer for *Health SA Gesondheid – Journal of Interdisciplinary Health Sciences*.

Moselene A.R. du Plessis
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa
Email: moselene.appel@up.ac.za
ORCID: https://orcid.org/0000-0002-1835-9893

Moselene A.R. du Plessis is a lecturer at UP. Her research interest lies in health care service management, leadership and indigenous knowledge system. She is actively involved in research projects under the ubuntu community model for nursing. She serves as a member of national (Gauteng Colleges of Nursing) and international (Africa Inter-professional Education Network) educational boards. She is a reviewer for two journals. She has published in accredited journals.

Nombulelo V. Sepeng
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa
Email: nombulelo.sepeng@up.ac.za
ORCID: https://orcid.org/0000-0001-9394-557X

Nombulelo V. Sepeng is a senior lecturer in UP's Department of Nursing. In 2011, she received an Atlantic Philanthropy grant to pursue her MA at NWU.

The University of California, Los Angeles awarded her the Tirisano pre-doctoral scholarship in 2016 to spend three months in Los Angeles learning about research methodologies in mental health care, trauma, rape, substance abuse and HIV and AIDS. For her PhD studies, she received an NRF-linked bursary. Sepeng received the following awards, the Golden Key internal honour society award, an award for 'Promising Young Researcher' and 'Best Researcher in Publications' as an emerging researcher. Sepeng has published 12 articles and supervised seven MA students and one PhD student in Nursing. Her primary areas of interest are females's health care, mental health care consequences and management of rape survivors and unplanned teenage pregnancies.

Ntsieni S. Mashau
Department of Public Health,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa
Email: ntsieni.mashau@univen.ac.za
ORCID: https://orcid.org/0000-0001-7104-6768

Ntsieni S. Mashau is a senior lecturer in the Faculty of Health Sciences at the University of Venda. She is currently the head of the Department of Public Health in the Faculty of Health Sciences. Her research interest lies in community health care and communicable and non-communicable diseases. She is engaged in a variety of projects focusing on community-based health care promotion. She is actively involved in the supervision of MA and PhD students. She has attended and presented research papers at national and international conferences. She has published articles in national and international accredited journals. She serves as a reviewer of articles for national and international journals.

Patience M. Tulelo
Department of Midwifery Nursing Science,
Gauteng College of Nursing,
Pretoria, South Africa
Email: mashtule@gmail.com
ORCID: https://orcid.org/0000-0002-8043-046X

Patience M. Tulelo is a lecturer at the Gauteng College of Nursing, SG Lourens Campus. Prior to her appointment as a lecturer, she practised as an advanced midwife and a reproductive health care nurse at Steve Biko Academic Hospital. She received a BCur in Nursing Education and Advanced Midwifery from the University of Johannesburg and a MA in Nursing Education from UP. Tulelo was a PhD candidate at UP. Her research interests are in indigenous knowledge and maternal and child health care.

Phumudzo Tshiambara
Department of Human Nutrition,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa
Email: phumudzo.mamphwe@up.ac.za
ORCID: https://orcid.org/0000-0002-3845-0256

Phumudzo Tshiambara is a new generation of academic programme lecturer at UP. She is a lecturer at the Department of Human Nutrition and PhD candidate in the Department of Consumer and Food Sciences at UP. Prior to her appointment as an nGAP lecturer, she was a National Research Foundation (NRF) intern at the NWU, Potchefstroom campus, where she also completed her MA in Science in Nutrition. She is a registered nutritionist with the Health Professions Council of South Africa. Her research interest lies in child and maternal nutrition, feeding practices, food and nutrition security and indigenous knowledge. She has published in the accredited *American Journal of Human Biology*.

Rachel T. Lebese
Department of Advanced Nursing Science,
Faculty of Health Science, University of Venda,
Thohoyandou, South Africa
Email: rachel.lebese@univen.ac.za
ORCID: https://orcid.org/0000-0002-3209-5660

Rachel T. Lebese is a research professor in the Faculty of Health Sciences at the University of Venda. Prior to her appointment as a research professor, she worked as a lecturer in the Department of Advanced Nursing Science at the University of Venda. Her research interest is in sexual and reproductive health care, HIV and AIDS, tuberculosis (TB) and indigenous knowledge. She has served as a leader in several research projects, such as the Breast self-examination project with CANSA (Cancer Association of South Africa) Limpopo province and the implementation of dialogues about sexual health care between teenagers and teachers/parents. She has published widely in accredited journals.

Rafiat A. Anokwuru
Department of Nursing Sciences,
Faculty of Health Care Sciences, University of Pretoria,
Pretoria, South Africa
Email: rafiat12@gmail.com
ORCID: https://orcid.org/ 0000-0001-8565-6305

Rafiat A. Anokwuru is a postdoctoral researcher with the South African Research Chair of Ubuntu Community Model in Nursing at UP. She finished her first degree in Nursing from Babcock University, Nigeria, her MA in Nursing from Loma-Linda University in California, United States of America and her PhD in Nursing from the University of Western Cape. She has published nine scholarly articles in accredited journals. Her research interest lies in maternal and child health care and nursing education.

Raikane J. Seretlo
Department of Nursing,
Faculty of Health Sciences, University of Pretoria
Pretoria, South Africa
Email: raikane.seretlo@up.ac.za
ORCID: https://orcid.org/0000-0001-6459-9065

Raikane J. Seretlo is a research assistant for the SARChI ubuntu model of nursing and an assistant lecturer at UP in the nursing department. He is a registered professional nurse with a MA in public health care and is an emerging researcher. His research interest lies in sexual and reproductive health care, digital health care and indigenous knowledge.

Ramadimetja S. Mogale
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa
Email: shirley.mogale@up.ac.za
ORCID: https://orcid.org/0000-0002-9434-3615

Ramadimetja S. Mogale is a professor and head of department in Nursing Science within the Faculty of Health Sciences at UP since 2020. Before this position, she was appointed as a senior lecturer and associate professor in the same department between 2014 and 2020. Her research interest is in female health care, with a broad focus on marginalisation and vulnerability that stems from clinical practice experience in community and primary health care. Thematically, this programme is about female's issues that cut across the social status of females on aspects such as violence against females, homelessness, disability, (en)gendering institutions and African indigenous knowledge systems. She constantly implores transdisciplinarity as the perspective in her research, teaching and learning endeavours. Additionally, she served as an associate editor for the *Ethnicity and Health* journal and a board member for the *African Journal of Midwifery and Nursing*. Her publication track record spans from 2010 in accredited journals and several book chapters in her area of interest.

Roinah N. Ngunyulu
Department of Nursing,
Faculty of Health Sciences, University of Johannesburg,
Doornfontein, South Africa
Email: rnngunyulu@uj.ac.za
ORCID: https://orcid.org/0000-0002-0632-4319

Roinah N. Ngunyulu is an associate professor of Midwifery and head of the Department of Nursing at the University of Johannesburg. She also worked as a senior lecturer for community nursing science and midwifery at UP. Her research interest is indigenous knowledge, maternal and child and community health care nursing. She is the coordinator of the student engagement portfolio at FUNDISA. She is a lead researcher from FUNDISA/NRF PLUME Cohort II project.

She has served as a chairperson of the research and social committee at Limpopo College of Nursing, Giyani Campus. She also served as the chairperson of the HIV and AIDS Committee at the UP in the Department of Nursing Science. She was a deputy chairperson of the community engagement committee in the School of Healthcare Sciences at UP. She has published widely in accredited journals.

Sanele Lukhele
Department of Nursing,
Faculty of Health Sciences,
University of Johannesburg,
Doornfontein, South Africa
Email: sanelel@uj.ac.za
ORCID: https://orcid.org/0000-0002-4283-3006

Sanele Lukhele is a midwifery lecturer at the University of Johannesburg and a PhD candidate at UP. Her research interest lies in maternal and neonatal health care as well as indigenous knowledge systems. In 2018, Sanele made it onto the *Mail and Guardian* '200 Young South Africans' list. She is also the recipient of the Gauteng Premier's Excellence Award in the health care category. She has recently been appointed to the Rural Health Advocacy Project (RHAP) Health Reference Group and is also a member of the steering committee of the Nursing Now Challenge on the Midwives in Focus.

Seepaneng S. Moloko-Phiri
School of Nursing,
Faculty of Health Sciences, North-West University,
Mahikeng, South Africa
Email: 16445198@nwu.ac.za
ORCID: https://orcid.org/0000-0001-5129-5564

Seepaneng S. Moloko-Phiri is the research coordinator for the postgraduate programmes at NWU (Mahikeng campus). She is an associate professor at the NWU involved in the learning and teaching of undergraduate nursing students. She served as a programme coordinator for the BCur undergraduate nursing students and MA programme at UP. Her research interest lies in females's health care, indigenous knowledge, human rights and nursing education. Her research work has been presented locally and internationally and has been published widely in accredited journals.

Tebogo M. Mothiba
Department of Nursing Science,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa
Email: Tebogo.mothiba@ul.ac.za
ORCID: https://orcid.org/0000-0001-9204-3654

Tebogo M. Mothiba is currently the executive dean of the Faculty of Health Sciences at the University of Limpopo and an NRF C3-rated researcher.

Her research interest lies in knowledge management of health care delivery. She co-authored 117 articles with colleagues, as well as MA and PhD graduates, along with research team members for research capacity development. She has also published seven book chapters. She is a reviewer for articles in national and international journals. Since 2016, she has served the Turfloop Research Ethics Committee as a nurse and became its deputy chairperson in 2019. She has worked as a principal investigator and co-investigator in various research projects. Mothiba has served as a research professor in the Faculty of Health Sciences at the University of Limpopo. She received five Vice-Chancellor's Research Excellence Awards at the University of Limpopo in 2013, 2016 and 2019. In 2013, the University of Johannesburg bestowed upon her the Best Academic Achiever Award for her PhD study.

Thifhelimbilu I. Ramavhoya
Department of Nursing Science,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa
Email: ramavhoya.i@gmail.com
ORCID: https://orcid.org/0000-0001-5065-9119

Thifhelimbilu I. Ramavhoya is a researcher, primary health care nurse specialist and a midwifery lecturer at the Department of Nursing Science. She is an associate professor at the University of Limpopo. She worked for 17 years as a clinical nurse practitioner and an acting operational manager in one of the primary health care facilities of Vhembe district. Her research interest lies in maternal and child health care, HIV and AIDS and work related to primary health care. She is currently a member of the Turfloop Research Ethics Committee at the University of Limpopo and a chairperson of community engagement. She is also a reviewer of articles in various journals, internationally and nationally, including being the co-editor of an Intech health care perspective book. She has published various articles in accredited research journals at national and international levels.

Tintswalo V. Nesengani
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa
Email: victoria.nesengani@up.ac.za
ORCID: https://orcid.org/0000-0002-0680-6844

Tintswalo V. Nesengani is a lecturer in Primary Care Nursing at the University of Pretoria, South Africa. Her research interest lies in 'CARING' for patients as practised in nursing. Prior to taking employment with the University of Pretoria, Tintswalo Victoria Nesengani was a manager for a primary health care clinic in the City of Ekurhuleni. She brings with her extensive knowledge and experience in clinical practice and has published some articles in accredited journals.

Introduction

Ramadimetja S. Mogale
Department of Nursing Science,
Faculty of Health Sciences,
University of Pretoria,
Pretoria, South Africa

This book presents a series of chapters that describe various ways of knowing and learning about indigenous health care practices in the African continent. The authors (un)ravel what is deemed unscientific in academia. Many African indigenous researchers persist in using Eurocentric paradigms to guide their research endeavours in the spaces they occupy. Among other reasons cited for the continuous use of Eurocentric paradigms in academia is the lack of acknowledgement of the histories, cultures and knowledge of indigenous people, particularly Africans. Additionally, available researchers with African and indigenous research focal areas blend their work with the Eurocentric paradigms for scientific acceptance. Those researchers and scholars who opt to pursue knowledge development from indigeneity and other African-based perspectives usually experience resentment in their research portfolios from those who perceive them as 'others'. In the scientific fraternity, a paradigm determines the interactions of the person or society with the world around them. Worldviews are passed on from one generation to the other for the sake of continuity. However, the worldviews of societies evolve with time and during their interaction co-learning occurs. However, it is a well-known fact that, with colonialism, co-learning never occurred. It is for this reason that today we

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come across African scholars and researchers who do not want to be associated with African and indigenous issues in their research portfolios.

The book's premise is based on the urgent need to (re)write and (re)look at African and indigenous health care ways of knowing. During the conceptualisation of this volume, the authors agreed to use indigeneity as a lens. However, the decision challenged the authors as there are few perspectives to tap into, especially as the health care system is heavily colonised. The dearth of such perspectives resulted in the expansion and inclusion of writings that used decoloniality, African-based, cultural and transcultural perspectives, as these are also emancipatory and culturally appropriate to guide inquiries into African health care problems.

As a lens, the concept of indigeneity became popular around the 1990s in academia, when many scholars and researchers from colonised communities fought against erasure, genocide and forced acculturation. One of the trailblazers to coin the concept was Smith (2000), a well-known indigenous Maori scholar who defines indigeneity as a critical theory that involves both indigenous peoples and researchers through critical reflection about the research phenomena for the practical solutions to their lives. When characterised as a theory, indigeneity in colonised countries emphasises the following: (1) recognition of the validity of the indigenous worldviews, (2) the identification of the opportunities to express what indigeneity is and the indigenous ways of knowing and doing and (3) creation of awareness and respect regarding the equal standing of other worldviews.

As a theory, 'indigeneity' was never intended to oppose nor denigrate known Western paradigms and perspectives. However, indigeneity is aimed at challenging indigenous researchers and scholars to investigate methods and inquiries that will preserve indigenous ways of knowing and learning. Of paramount importance is the fact that this paradigm is about the development and empowerment of indigenous people on issues of concern in their lives. Scholars and researchers across the globe who ascribe to indigeneity identify the common principles as the recognition of the connectivity and relationship of the living and the dead on creation and translation of knowledge through the spiritual world, the existence of multiple truths and the wholistic nature of knowledge, its dependence on the lived experiences and equality of all creatures with the humans being the least important factor in their scholarship and research.

That said, a pondering question in countries such as South Africa where colonisation persists to exist is, who are the indigenous people? The preferred characterisation to answer this question is provided by José Martínez Cobo (1986), a special rapporteur for the United Nations Sub-Commission, who emphasises that the definition of indigenous people is contextually and

continentally bound in accordance with membership and history. Hence the definition states that the 'indigenous people, communities and nations are the groups that have a "historical continuity with pre-colonial societies" within territories they have developed and consider themselves distinctively as indigenous'.

The immense scholarship that emerged in many MA and PhD theses that were reviewed for the conceptualisation of this volume indicates the emic stance of the authors' team as Africans and indigenous. This viewpoint provides a meaningful scholarship on African and indigenous knowledge systems to (re)claim the indigenous ways of learning and doing things in all spheres of life, including health care issues. Additionally, the stance (re) incorporates the experiences of African people and these scholars in the chapters. All the chapters in this book report the research findings that are used in an array of qualitative research designs.

The chapters provide essential knowledge that needs to be appreciated regarding the lives of African and indigenous people throughout their lifespans. And these chapters are about how diseases and ill health care may be prevented and treated from the indigenous African perspective.

Chapter 1 is on the communication discordance between health care professionals and indigenous patients. Chapter 2 delves into the indigenous practices in health care promotion and disease prevention. In Chapter 3, the authors explore the wearing of artefacts for preventive and promotive care: An African indigenous practice for '*go thekga*' during infancy. Chapter 4 expounds on the rite of passage: An African indigenous knowledge perspective, with Chapter 5 dealing with child spacing and prevention of pregnancy among African indigenous cultures. Throughout Chapter 6, the authors discuss the African indigenous beliefs and practices during pregnancy, birth and after birth, and Chapter 7 expounds on the provision of neonatal care. An African indigenous perspective, indigenous knowledge, beliefs, practices and treatments of menopause amongst females of African descent are discussed in Chapter 8, while Chapter 9 discusses sexually transmitted infections (STIs) in an indigenous African context. Chapter 10 provides insights into indigenous health care practices in the treatment of mental illness in South Africa, and Chapter 11 is an integrative review conducted on same-sex intimacy, relationships and marriages among African indigenous people. In Chapter 12, the authors elucidate the role of patriarchy and its influences on domestic violence against females and children in Africa. Chapter 13 discusses the nutritious edible indigenous vegetables.

It is hoped that the book will bring back African hope, dignity and creativity to the traditional health care and knowledge systems locally and internationally.

Disclaimer

The book is based on the continuous collaborative research efforts that the current NRF-funded Research Chair for Albertina Sisulu on the Ubuntu Model of Nursing Science has established for the past decade with the following universities: the University of Pretoria, North-West University (NWU) Mafikeng Campus, University of South Africa, University of Venda and the University of Limpopo as well as Tompi Seleka Agricultural College. The authors are from different disciplines pursuing transdisciplinary research endeavours.

Chapter 1

Communication discordance among health care professionals and indigenous patients

Seepaneng S. Moloko-Phiri
School of Nursing,
Faculty of Health Sciences, North-West University,
Mahikeng, South Africa

Nombulelo V. Sepeng
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Jeanette M. Sebaeng
School of Nursing,
Faculty of Health Sciences, University of the Free State,
Bloemfontein, South Africa

Abstract

The main intention of communication is to send a message that should produce meaning and be understood by the receiver. The message can be either verbal or non-verbal. Communication plays a pivotal role within the health care setting as health care professionals use it to collect history from the patients, and this enables them to diagnose the disease and

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intervene appropriately. However, in most cases, there is a communication discordance between indigenous patients who are unique holders of knowledge and languages used in their communities, which are different from that of the health care professionals. The discord in communication is mostly because of health care professionals and indigenous patients using different languages to communicate, which results in a lack of understanding. Often, health care professionals do not understand the language used by indigenous patients and vice versa. Also, health care professionals use medical jargon to explain sickness and diseases. They often misinterpret and misunderstand patients who do not speak western languages. Equally, non-verbal cues used by indigenous patients can lead to communication discordance. Although this is the case, communication discordance among health care professionals and indigenous patients is not documented in the literature. Therefore, this chapter discusses the use of verbal and non-verbal communication by indigenous patients and how they should be interpreted by health care professionals. Measures that can be taken to overcome communication discordance between health care professionals and patients are also outlined. Also discussed are the communication discordance implications on disease management.

Effective communication versus communication discordance

According to Mundy and Lloyd-Lane (1992), the way health care professionals behave and speak, even in their silence, and their style of work sends out numerous messages to those around them. Human beings communicate and interact with each other in terms of language, which constitutes verbal and non-verbal cues (Ntuli 2012). Aruma (2018) asserts that communication is a process by which people exchange information and express their thoughts, feelings and ideas with each other. During their interactions, health care professionals come across patients who are not only different in their culture but also in verbal and non-verbal communication. The use of different verbal and non-verbal cues by health care professionals and indigenous patients can result in communication discordance.

In Africa, health care professionals are taught and operate in languages that are different from those of the indigenous people they care for. Therefore, caring and effectively communicating with patients becomes a challenge. In most cases, the medical language cannot be easily translated into indigenous languages making it more difficult for health care professionals to give relatable information to patients. Among the common challenges health care professionals face in communication, the most prominent appears to be the different languages used by patients and the varied cultural practices presented. This is a major challenge as it affects patient safety and threatens

their well-being. When patients cannot communicate with health care professionals, they lose the opportunity to access quality services and make informed decisions regarding their health. In this chapter, the communication discordance between health care professionals and indigenous patients is discussed. The chapter also highlights the pivotal role of effective communication between health care professionals and indigenous African patients.

The use of South African official languages

The Pan South African Language Board (PanSALB) is a constitutional institution established to regulate and monitor the development of languages in South Africa. It also ensures that the citizens use the official languages of their choice to communicate and access information and government services. The PanSALB was established in accordance with Section 2 of the *PanSALB Act of 1995*. It is mandated to promote multilingualism and protect language rights, particularly for previously marginalised languages. To promote parity and equitable treatment of the national languages of South Africa, Section 2(2) of the *PanSALB Act of 1995* as amended asserts that government should take practical and positive measures to elevate the status and advance the use of indigenous languages as indicated in Section 6(2) of the Constitution. The *PanSALB Amendment Act 59 of 1995*, Section 2(3) enables all South Africans to use the official languages of their choice as a matter of right and to ensure equal access to government services and programmes. Furthermore, subsection 2(6) promotes *ubuntu* in the use of languages through the promotion of multilingualism and language diversity. As such, it is imperative that health care professionals must accommodate and learn at least one of the languages of the indigenous community they serve.

The importance of indigenous communication in the health care system

Through language, people communicate and convey ideas, opinions and thoughts. Jennings, Bond and Hill (2018) argue that communication is an important element in the health care system because it can improve cultural acceptability and access to health care services. Despite the efforts put in place to address the issue of language in South Africa, indigenous patients have limited access because of language when consulting within the health care system.

Multilingualism between health care professionals and patients is a challenge within the health care systems in South Africa, just like in any other country with a similar situation (Claasen et al. 2017). This could be because indigenous ways of communication are not considered important. After all,

not much has been done to curb the communication discordance between health care professionals and indigenous patients. Naidoo (2014) and Miller (2011) argue that language issues in Africa continue to compromise patients' access to health care services. A qualitative study conducted by Kelly, Mrengqwa and Geffen (2019) reveals that participants expressed a lack of patient-centredness caused by poor communication, leading to non-utilisation of health care services and poor compliance with treatment.

According to Hussey ([2012] 2013), past historical legacies and disparities in South Africa continue to compromise indigenous people's access to health care services. When an indigenous patient enters the consultation room, health care professionals should be aware of the patient's language limitations and cultural beliefs with regard to their illness and should be treated with respect (Bakić-Mirić et al. 2018). Therefore, patients should be permitted to use the language of their choice to openly and honestly discuss their illness and alternative treatments they are taking without fear of being judged.

According to Fernandes et al. (2020), patients visiting a clinic in Makwarela in the Limpopo province of South Africa expressed different experiences with nurses' interactions. In the same study, literate patients reported positive experiences regarding the time spent with the nurse, unlike those that are less literate. It is evident that patients' literacy level counts in their achievement of health care outcomes. Consequently, the International Center for Health Care Strategies (2013) maintains that the elderly often experience low levels of health care service access. The same report posits that, in most cases, health care professionals who do not speak the patients' language often make medication errors. Similarly, patients misunderstand the instructions and fail to comply with treatment. Therefore, they present with increased readmissions and prolonged hospital stays.

The language barrier decreases the work efficiency of the health care professionals, and it therefore becomes difficult for them to be empathetic and provide the best care for patients (Hussey [2012] 2013). Hussey ([2012] 2013) further reports that compliance to treatment is a challenge that might be because of verbal and non-verbal communication. During hospitalisation, indigenous patients often experience anxiety because of poor knowledge of the medical jargon, which often creates a communication gap and ultimately negatively impacts their health care outcomes (Amery 2017). According to Amoah et al. (2018), the medical language used within the health care system is often threatening and confusing to patients. The jargon is often frightening to patients who prefer that the language used should be accessible and easy to understand. Despite this, health care professionals are expected to be culturally aware when caring for patients to ensure that patients receive accurate information about their care. The ability of health care professionals to understand the landscape of the indigenous language is equally critical in

the health care environment as this also facilitates the healing process. As such, health care professionals need to accommodate patients and allow them to communicate in their languages.

Types of communication that may lead to discordance

Human beings use verbal and non-verbal ways of communication and much of what is communicated is based on different cultural values and beliefs. Each type of communication will be described in relation to how health care professionals and patients express themselves within the health care setting and also how their expressions contribute to communication discordance.

Verbal communication

Verbal communication refers to the way of connecting with a person by using spoken language (Purwaningsih & Dewi 2019). Often, indigenous patients use their languages to tell the health care professionals about issues pertaining to their health. Health care concepts are embedded in culture and, therefore, communication about the health care needs of patients should take into consideration the multicultural discourse (Lê 2006). Generally, in Africa, when indigenous patients present at the health care services, they often use phrases that are not commonly used in everyday spoken language to present their problems or symptoms. The use of these phrases often creates communication discordance among them and the health care professionals. Additionally, the phrases used by indigenous patients during their communication do not have a fixed meaning and may not be understood by some health care professionals. For example, some cultures prefer the usage of euphemisms to show politeness and respect or when referring to something embarrassing. Euphemism is defined as mild or indirect words or expressions used to substitute ones considered harsh or blunt (Herbert 2016). For example, a Motswana male during a consultation may say '*ke na le bothata mo bonneng ba me*', literally translated as 'I have a problem with my manhood', which basically means 'I am experiencing a problem with my genitals'. This is because human beings are social and cultural beings and, therefore, inappropriate use of descriptive words may cause embarrassment and a serious communication breakdown. However, this may cause a serious challenge, especially when the health care professionals do not understand the meaning of what is communicated.

Hondras et al. (2015) report a challenge in understanding how the Batswana perceive and talk about pain. A general term for pain, both physical and emotional, is *botlhoko* in Setswana and *bohloko* in Sesotho and Sepedi. Most patients apparently used the term *botlhoko*, implying whole-body pains (Hondras et al. 2015). Hondras et al. (2015) state that *botlhoko* results in the

expansion of its nature to words such as *thunya*, *tsunyetsa* [pricking], *setlhabi* [pricking] and *bogatsu* [pins and needles], which are used interchangeably. Batswana of Botswana rarely refer to lower back pain or back pain. They would rather use terms such as *letheka* or *dinoka*, which both literally translate into 'waist-related' pain, and they refer to muscle pain as 'meat on my back' (Hondras et al. 2015). Although the Setswana word *botlhoko* is used for pain, it does have different meanings in English, such as pain, illness, disease and spiritual anguish. Furthermore, using the word *botlhoko* requires that health care professionals probe and question further about the related attributes and contextualise them to the pain. It is therefore important for health care professionals to know the local language to be able to respond effectively.

Health care professionals must probe further to understand what the patient is referring to in the narratives during consultation. The use of metaphors to describe pain and distress by different cultural groups can cause misunderstanding (Van Den Berg 2016) and leave patients with continuous untreated pain and distress. For example, in Setswana patients may say '*E ka re ke rwele letlapa mo thlogong*', expressing that the headache feels like a heavy stone being placed on top of their head. The semantics for pain expression may be important for health care professionals to institute proper intervention strategies.

In Zimbabwe, a Shona female may report at the health care centre complaining of '*jeko gadzi*', which is said to be the milder type of menstrual pain, or a child who is sick and brought to the hospital because of '*chipindira*' or failure by the infant to suckle (Mpofu & Mangoya 2005). Further questioning of the concepts is necessary for clear understanding.

In a study conducted by Claasen et al. (2017) in Cape Town, South Africa, at the Red Cross Children's hospital, there is a discordance of words used to describe illnesses whereby parents use terms culturally known to them, and this leads to miscommunication with the doctors. For example, '*isifuba*' was often used by parents, meaning chest disease, which does not necessarily correlate with '*e-esma*' (asthma). In the study, doctors were encouraged to interrogate further should the mother say her child has '*e-esma*' because some refer to '*isfuba*' as asthma. This implies that health care professionals should be aware of some discordant medical terms that patients might use. As health care professionals, having knowledge of the different languages and the expressions used by patients to report diseases and may improve patient care and lead to good health care outcomes.

It is therefore important that health care professionals probe patients further to understand what could be wrong. When probing, health care professionals must listen to the tone of voice the patients use when they express how they feel to understand the intensity of the problem. They must also understand the ways of communication commonly used by patients so

that they can give information that will assist them in decision-making and informed consent regarding their health care (Naidoo 2014). According to Mathews (2018), 77.8% of patients in KwaZulu-Natal speak isiZulu, and medical students are expected to communicate with them in the language. The author further asserts that in the current programme, medical students are taught their first-year module in family and behavioural medicine in isiZulu. The module also focuses on a patient-centred approach in the context of clinical skills. The decision to include isiZulu in the training of all non-mother tongue students was made by the university in 2014, followed by the call of the Minister of Higher Education, Blade Nzimande, who recommended that universities must promote multilingualism (Naidoo & Gokool 2020). On the contrary, Mathews (2018) found that medical students at the University of KwaZulu-Natal did not benefit much from the inclusion of isiZulu in the programme because the process did not promote the ability to use the language in a clinical setting.

Local languages must be incorporated into health care professionals' curricula, including how patients use their local languages to express any form of the disease. When interacting with a patient who is using a local language, health care professionals must also use probing skills. For example, *isifuba* can be a symptom of many medical diagnoses, so determining which type of *isifuba* the patient is referring to is critical in making a proper diagnosis and prescribing treatment.

Non-verbal communication used by indigenous patients

Non-verbal communication refers to a sign or silent language that also includes behaviours demonstrated in the presence of other people, perceived either consciously or unconsciously (Bambaeeroo & Shokrpour 2017). In addition, the authors assert that non-verbal communication is subtler and more effective and can convey the message more effectively as compared to verbal communication. Furthermore, according to Lamichhane (2016), non-verbal communication imparts emotional messages where the feelings, attitudes, knowledge and intentions of the sender are made clear. Despite this, anyone, including health care professionals, can misinterpret the communicator's non-verbal communication.

Health care professionals should not rely solely on non-verbal communication when patients present with challenges within the health care system. It is the health care professional's responsibility to use verbal communication to inquire further about what the patient intends to communicate. In support, Nenungwi (2015) argues that non-verbal communication is often considered less accurate as compared to verbal communication, and this is because different cultures interpret body gestures, language and postures differently.

Therefore, this may lead to communication discordance among health care professionals and indigenous patients. For example, in Tshivenḓa, making eye contact is often considered disrespectful when a young adult speaks to an elder (Nenungwi 2015). In this instance, health care professionals should understand the non-verbal gestures displayed by the patient. In other cultures, especially the Nguni cultures, it is not appropriate for a female to look directly into the eyes of a male person. This behaviour of not looking at someone straight in the eyes signifies respect in most African cultures. However, most health care professionals may conversely interpret that as being untrustworthy or guilty.

Health care professionals are also expected to be aware of gestures that are used to express pain. For instance, a patient who is in pain may present with a sad face and teary eyes and a curled position without saying anything to a health care professional. Therefore, health care professionals should practice patience and use their observation skills to diagnose pain until such time the patient can verbalise the type of pain they are experiencing. Another non-verbal communication used by patients to express themselves is by displaying the anatomical structure. They display the anatomical structure to the health care professionals as a form of showing the pained area. Therefore, if the health care professionals do not understand what the patient is communicating, they will use verbal communication to probe further, which will enable them to examine the affected part and make a proper diagnosis. In other instances, waist-related pain is depicted by placing the hand across the lower back (Hondras 2015).

Kwame and Pertucka (2020) argue that health care professionals bring their respective knowledge, attitudes, feelings, experiences and patterns of behaviour during their interaction with patients. They further emphasise that these behavioural patterns and perceptions demand the implementation of different communication styles to meet the needs and health care expectations of patients. Non-verbal cultural values are therefore important and are to be recognised by health care professionals. It is for this reason that health care professionals are to recognise and realise that non-verbal cultural values are an important means of communication that can prevent discordance and help to reach an understanding.

Importance of non-verbal communication by health care professionals

Lorié et al. (2017) reported that non-verbal expressions of empathy, such as nodding the head while the patient is talking, are a crucial component of cross-cultural competency that also focuses on empathy and trust for patients. It therefore increases the clinical competency of the health care professionals. Ahmed (2020) reports that health care professionals use non-verbal cues to

communicate positively with patients. These include being tidy and neat on duty, using facial expressions to convey interest, paying attention and using a professional tone of voice that conveys sympathy and attentive listening. In such instances, patients feel welcomed even though there is a lack of a common language of communication. Therefore, health care professionals must continuously use these non-verbal communication skills when engaging with patients as a form of showing them respect and sympathy.

Silence as a means of communication among indigenous people

Silence conveys a message just like other forms of communication (Agyekum 2002) and is not much spoken about among indigenous people. According to Bagwasi (2012), silence is the absence of sounds or words in a conversation. In indigenous knowledge, silence may be viewed as positive or negative and is often supported by idioms. Agyekum (2002) maintains that silence may be used as a sign of powerlessness, and this may prevail within the health care settings as there is a power imbalance between health care professionals and patients, particularly regarding health care knowledge. Therefore, health care professionals should avoid dominating patients by using medical jargon or language that they do not understand, as this might make patients opt to keep quiet rather than engage with the health care professionals. In such instances, health care professionals should reduce the use of jargon and terminologies when communicating with the patients to prevent the use of silence as a form of communication because patients will leave the hospital and never come back, leading to defaulting on treatment.

Patients may also choose to remain silent when the health care professionals display dominance. Agyekum (2002) reports that the Akan people of Ghana use silence as a form of communication and have an expression such as '*memmeue m'ano*', meaning 'I will not open my mouth'. This occurs in a situation where individuals feel powerless and frustrated and deem it better to keep quiet. Batswana people have several idioms attesting to this, such as '*go tima motho mafoko*', '*go itlhaba ngololo*' and '*go roka molomo*', which all mean to keep quiet or give someone 'the silent treatment' (Bagwasi 2012). These idioms reveal a deliberate action by the speaker to disrupt the order of the conversation by restraining themselves from speaking when expected to. Therefore, health care professionals should learn about these different types of conflict management used by indigenous patients when they are experiencing challenges. If this is happening, the health care professionals should ask the patient about issues that angered them, ask for forgiveness and, where possible, refer the patient to the next health care professional who might enable the patient to open up and eventually receive appropriate treatment.

In other instances, health care professionals must be aware that patients may choose to remain silent during their interactions because they are in pain or anxious. Therefore, health care professionals should use their observational skills to ascertain whether the patient is experiencing excruciating pain or anxiety. Based on their findings, they should ask the patients questions to confirm whether or not they are in pain or feeling anxious. Thereafter, calm and reassure the patients that they must express themselves freely.

On the other hand, children are expected to remain silent in the presence of adults as a symbol of subordination or respect (Bagwasi 2012). Whenever children are talking when elders are communicating, this can spark conflicts between them because it is regarded as disrespectful. Therefore, health care professionals need to practice patience and understand that children might delay answering when they are in the consulting rooms because of fear of interrupting elderly people's conversations.

The use of proverbs, idiomatic expressions and riddles as a means of communication discordance between patients and health care professionals

Proverbs

Proverbs are also seen as the force that drives words in communication and makes them drive through the audience, giving a lasting effect (Ik-Iloanusi 2021). According to Fayemi (2009) (cf. Grant & Asimeng-Boahene 2006), proverbs have their origin in oral tradition, provide meaning to experiences and expressions related to culture and are used to guide and incorporate values and beliefs that are passed down from generation to generation. Proverbs are part of the tradition and have been used since time immemorial. Mugovhani (2014) contends that the VhaVenḓa have *mirero* proverbs, *maambele* idiomatic expressions and *dzithai* riddles that are used as the indigenous way of advising, guiding and supporting, or reprimanding as part of their linguistic vocabulary. For example, '*tshilonda tshi vhavha mukweti*' or *'ndi a vhavhiwa li na mulwadze*' refers to how whoever is sick can best feel the extent of the sickness or pain. This implies that health care professionals should always know that when a patient complains of pain, it should always be considered. For instance, in Nigeria, the Yoruba proverb '*Oògùn kì í gbénú àdó jé*' means that an unused charm does not prove its efficacy. It further means that any patient who has medications in his possession must take them or apply them for healing to take place. Furthermore, it is believed that '*Gbà-mu, Kò tánbà*' refers to how one can never get a fever to subside without taking the appropriate dosage. This implies that whoever would like to be healed should abide by the prescription. As such, health care professionals should

always educate patients about the importance of taking their treatment as indicated on the prescription to achieve good health care results.

Riddles

Riddles are used to conceal or hint at something. Akhabue (2006, cited in Mugovhani 2014) indicates that the hint usually induces an explanation and always obscures the meaning. For example, Batswana often says '*tlhotsa pele ga se eswa pele*', meaning that the person who falls sick first will not necessarily die first. This riddle is usually used when a sick person feels that there might be a complication or death. This is because an illness is often a reassurance that one is sick and does not imply that the person is dying.

Idiomatic expressions of distress

Nichter (2010), in a study on the idioms commonly used to assess the interpersonal, social and spiritual sources of distress among psychiatric patients, indicates that knowledge of idioms of distress made the researcher pay more attention to the cultural issues of illness and treatment given to psychiatric patients. For instance, recognising the idioms of stress also assists in building rapport and being more empathetic. According to Nichter (2010), idioms of distress are the cultural and social means of experiencing distress, such as past traumatic memories and current stressors such as anger, hopelessness, insecurities and feelings of anxiety, among others. Health care professionals should know the idioms that the patients are using to describe any form of disease so that they can be able to assess and identify idioms of distress that indigenous patients may present with. Similarly, Mendenhall et al. (2019) describe the idioms of distress as constructs used by anthropologists who want to understand the languages used by individuals from other socio-cultural groups to express illness or pain. Therefore, when health care professionals understand the languages used by indigenous patients to express their suffering, they will be able to support them and provide appropriate care. For example, Mendenhall et al. (2019) report that in Kenya, in Kiswahili, idiomatic expressions such as '*huzun*', which means sadness or grief, are used to describe how patients feel when grieving, and '*kufikiria sana*', which refers to how thinking too much about something is depressing is a powerful cultural idiom which is a form of psychological distress.

Social norms and values to be displayed when communicating with indigenous patients

There are social norms and values about the beliefs held regarding what is right or wrong during communication by varied indigenous communities.

Culture is what makes people distinct from each other (Idang 2015). Often there is a misunderstanding in ways of communication and their interpretations. As such, health care professionals can experience challenges in their encounters with indigenous patients, thus leading to the provision of insensitive care. In this regard, Purwaningsih and Dewi (2019) posit that communication with patients using polite words can fast-track the process of healing. In Africa, words are accompanied by what is deemed cultural appropriateness. For instance, when indigenous patients enter the health care system, they can greet the health care professional verbally and or practice other cultural norms and values to demonstrate respect. The greeting is expected to be exchanged at the point of contact between any two people (Bagwasi 2012). Furthermore, greetings are so far an acknowledged marker of positive politeness and their main social function is to establish interpersonal relationships. Among Africans, greetings form an integral part of etiquette and *ubuntu*. *Ubuntu* (humaneness) is a characteristic of the indigenous knowledge system which shows caring and kindness. Younger children are not supposed to call the older persons by their names when greeting each other but rather address them as *mama* when talking to females *or baba* when talking to males, *mkhulu* when talking to grandfathers or *gogo* when talking to grandmothers in isiZulu (Ntuli 2012). This means that when indigenous patients are greeting male health care professionals, they will address them by saying *molo tata* in isiXhosa. Therefore, they would expect health care professionals to greet back in the same way which might not be the case if the health care professionals are from a different culture, especially if they see nothing wrong with calling an elderly person by their name.

These social norms and values of greeting each other comprise several forms of gestures such as handshakes, winking, taking off hats, bowing and kneeling. Greetings may also differ between genders depending on socialisation. In other cultures, females bend the knee as a greeting. This act of bending a knee is performed only by females and it reduces the person's height, making them look shorter and smaller (Bagwasi 2012). The bending of the knee is performed by females in reverence to males and other females highly respected in the community. Males, on the other hand, display reverence to other males who are culturally senior to them by taking off their hats during greeting but may not perform the same act for females unless they are a chief's wife or closely connected to royalty. Conversely, bending and kneeling among the AmaZulu is performed by females when asking for something from their husbands and when they bring the husbands food (Ige & De Kadt 2002). In Tshivenḓa, kneeling is part of the greeting *ndumeliso* or *ulosha*, which is shown by humbly putting the palms of the hands together (Nenungwi 2015). It is important for health care professionals to recognise and know the different ways of greeting and what they signify to establish rapport and provide culturally congruent care among indigenous patients.

Similarly, younger persons are expected to initiate a greeting when they meet an older person in the street or market. There is a similar expectation from the health care professionals when they first meet their indigenous patients in the health care setting. However, in a case where the person arrives at home or where other participants are already seated, greetings may be initiated by whoever is arriving. In this instance, it will be expected that health care professionals must greet the patients that are admitted into the wards, and they must always greet them appropriately to create rapport.

The importance of effective communication between health care professionals and indigenous patients

Effective communication between health care professionals and patients enables a good understanding of the conditions and treatment modalities and allows them to make informed decisions. The communication gap between health care professionals, patients and their families can create serious consequences such as poor access to health care services, incorrect diagnoses and improper treatments, including non-adherence to prescribed medications, among others (Kelly et al. 2016).

Consequently, effective communication within the health care environment ensures that patients receive timely, accurate and relevant information in the language of their choice or through videos or posters with a focus on culturally-sensitive information. Without improved health care literacy, patients and their families may not be stimulated to take in the information that benefits their health care. Furthermore, when indigenous patients feel that they are involved in effective communication with health care professionals and their trust is strengthened, this leads to positive patient outcomes (Jennings et al. 2016; Patel et al. 2013).

Use of pamphlets to mitigate communication discordance between patients and health care professionals

Poplas-Susi et al. (2014) assert that patients can read about their treatment even if information leaflets and materials are frequently written in language that is too scientific and occasionally too ambiguous to grasp. This means that patients can read the information during their spare time so that they can internalise and understand it. Although the challenge may often be the low levels of literacy and education to understand the information. Owusu et al. (2020) conducted a study in Ghana on the role of a patient information leaflet on medication therapy; the study recommended that the pamphlets

be issued in the local dialect because of some low literacy levels among certain patients. It is imperative to develop manuals that can be used by health care professionals to refer to when patients are visiting the health care system and express their sickness through their languages. It is also important to offer health care professionals language support to help them provide holistic care to patients.

Use of an interpreter to mitigate communication discordance between patients and health care professionals

The absence of professional interpreters is a challenge. The absence is partly because of several issues such as financial constraints and logistics within the health care system (Claasen et al. 2017). For example, in Cape Town, health care professionals are expected to at least be able to speak isiXhosa or Afrikaans to be relevant to the context, and this has led to the development of course material for basic language training through the cooperation with Northern Tygerberg substructure clinics and the division of the family medicine.

Furthermore, a study conducted in the Eastern Cape, South Africa, on still lost in translation barriers (Van Den Berg 2016) reports that the inability to speak isiXhosa made the health care professionals not display empathy and not appear welcoming to patients. Failure to understand the patient's language and the use of interpreters often create a worrying situation where patients cannot internalise their diagnosis, treatment and care. Similarly, some health care institutions use interpreters to ensure that patients are fully understood. Despite these mitigation risks to overcome language barriers, there is still a lot that needs to be done to ensure that patients access quality health care.

Recommendations

There is a need to educate health care professionals about the importance of multicultural communication when patients are presenting themselves within the health care system. The education must cover both verbal and non-verbal cues used by Africans when presenting their sicknesses and diseases within the health care system. There is a need to target linguistic departments to translate the medical jargon used within the health care system to provide patients with simplified words that they can grasp easily and remember so that they can adhere to the treatment regimen provided. It is also imperative that linguistic departments translate common diseases that African people can present with within the health care system. This will assist health care professionals in caring for clients without stigmatising them and, where possible, referring them to traditional health care practitioners.

The various Departments of Health must budget for the provision of language aid services such as interpreters and employ multilingual staff to improve communication with indigenous patients. In trying to curb communication issues in the hospitals in the Western Cape province of South Africa, the Department of Health (DoH) in collaboration with the provincial government, Extended Public Works Programme (EPWP) and Stellenbosch University (SUN) trained and placed community interpreters in hospitals. These community interpreters are isiXhosa first-language speakers with Matric and received three-day intensive training in interpreting (Benjamin et al. 2016). This can be another strategy adopted by other provinces and other African countries to mitigate communication discordance between patients and health care professionals.

Health care professionals are expected to promote dialogue across different cultures and develop indigenous theories from different health care locations, which will assist in the concepts to be used when caring for indigenous patients (Adhikary 2012). These can include common vocabulary that patients use to report an illness, signs and symptoms. Furthermore, Kwame and Petrucka (2020) suggest that patients' concerns about cultural or religious expectations, which often clash with health care processes, must be addressed. For example, indigenous patients are to be listened to, educated and provided with the relevant information to encourage them to trust and take active participation in their health care.

Offering communications skills imparted to health care professionals equips them to be multilingual, therefore allowing patients to communicate about their illnesses in their mother tongue. Policymakers and health care providers are to provide intercultural awareness translated into practice to ensure that people are not excluded from participating meaningfully in their health care (Lê 2006). There should be the inclusion of communication skills in the training programmes of all health care professionals, as this will assist in identifying the cultural health care needs of patients (Fite et al. 2019). It is recommended that a non-western curriculum for health care professionals, including allied professionals, should be drawn on the indigenous perspectives and incorporate relevant concepts that can be used to improve communications.

Conclusion

Verbal and non-verbal communication plays a significant role in the engagements between health care professionals and patients. Health care professionals need to understand how patients present their sicknesses within the health care system. Patients have a right to use their language choice to present their sicknesses and diseases. The latter is not taught to health care professionals during their training, and the curriculum needs to be updated to include this. At times, the way patients present themselves does not relate to

any anatomical structure written in the book but to them trying to express themselves as being bewitched. Although this is the case, health care professionals need to recognise and understand the cues. Additionally, health care professionals should be able to observe the non-verbal cues used by patients when they arrive at the hospital. These non-verbal cues may assist health care professionals in identifying the anatomical structure that is affected regardless of not understanding the language used by the patient. From there, health care professionals will be able to probe the patients further to understand what could be the health care problem that brought the patient to the health care system and therefore make the proper diagnosis and give relevant treatment. Health care professionals also need to learn the non-verbal cues that can be used by indigenous patients during conflict management. They also need to learn how to carry themselves when caring for older and younger patients.

Glossary

- ***bogatsu*:** Numbness
- ***bohloko/botlhoko*:** Pain
- ***chipindira*:** Failure by the infant to suckle
- ***dzithai*:** Riddles
- ***e-esma*/asthma/*isfuba*:** Chest disease
- ***huzun*:** Sadness or grief
- ***isifuba*:** Chest disease
- ***jeko gadzi*:** Milder type of menstrual pain
- ***kufikiria sana*:** Psychological distress
- ***maambele*:** Idiomatic expressions
- ***mirero*:** Proverbs
- ***ndumeliso/ulosha*:** Greeting
- ***thunya/tsunyetsa*:** Pricking pain
- ***ubuntu*:** Humaneness

Chapter 2

Indigenous practices in health care promotion and diseases prevention

Thifhelimbilu I. Ramavhoya
Department of Nursing Science,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa

Tintswalo V. Nesengani
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Abstract

Indigenous practices in health care promotion and disease prevention are utilised by millions of people all over the world. However, such practices are not well-documented. Indigenous practices are easily available, affordable, accessible and accepted by most people in various communities around the African continent. As such, this chapter outlines the role of traditional health care practitioners in disease prevention and health care promotion; the role of indigenous practices such as activities and food in health promotion and diseases prevention; taboos and diseases prevention; and challenges faced by traditional health care practitioners and their referral system. Apart from traditional practitioners, indigenous remedies are mostly applied by older people though the young can also utilise them without prescription, for

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example, the utilisation of *Artemisia* herbs called *tshiumbeumbe* among VhaVenḓa and *serokulo* among Batswana for the prevention and treatment of minor ailments like *mukhuswane*, also known as the 'common cold'. Other indigenous health care promotion practices utilised by Africans as a form of exercise include traditional dances such as *tshigombela*, *malende*, *muchongolo*, *xifasi* and others that aid in the prevention of non-communicable diseases. As such, health care professionals must be made aware of these practices as they are beneficial in health care promotion and disease prevention. Health care professionals should encourage patients to continue with good practices such as consuming indigenous foods (fruits, vegetables, insects, etc.) to promote their health and prevent diseases.

Health care through indigenous practices

Indigenous or traditional health care is the cornerstone of health care service delivery in most African countries and it still remains important to many people irrespective of the fact that they are using western medicine (Nemutandani 2016). The majority of Africans utilise natural resources such as herbs, roots and leaves in health care promotion and disease prevention and access their health care services through traditional health care practitioners and traditional medicines (Foster & Anderson 1975). As such, the World Health Organization (WHO) 2003 estimated that 80% of African people are utilising traditional practices (Madamombe 2006). In South Africa, studies have shown that 60% of the population utilises traditional health care practitioners and traditional medicines, although some people utilise both (Department of Health [DoH] 2010).

Traditional medicines are offered by various indigenous knowledge holders, for example, those who have a calling and have undergone the relevant training, untrained practitioners and some elders who know about indigenous remedies. In 2010, there were approximately 200 000 indigenous or traditional health care practitioners as compared to 25 000 health care professionals in South Africa (DoH 2010). Traditional or indigenous practices are favoured because they offer holistic health care services to patients. The practices include promoting and preventing diseases and cure and rehabilitation. Traditional health care practitioners mostly care for their patients in their homes; hence their services are preferred because of accessibility, affordability and availability. It is undeniable that they can be used as a tool to help achieve optimal health care for indigenous communities (Janzen 1992; Mabena 2020). Both the educated, employed, illiterate and unemployed people in various African countries, including in the diaspora, seek health care through indigenous practices. According to Zhang (2015), countries such as Singapore and Korea (both South and North) still use traditional medicines (76% and 86% respectively), even though their health care systems are well-established.

As indicated, in some instances indigenous remedies are offered by healers or knowledge holders who did not undergo training. This happens mostly in the utilisation of the herbs, that is, *Artemisia* – called *tshiumbeumbe* in Tshivenḓa or *serokolo* in Setswana – and *Eucalyptus paniculate*, called *mubomo* in Tshivenḓa (Ang et al. 2020; Flores 2018; Yang 2020). These leaves are utilised by many people in Zimbabwe and South Africa. They can be referred to as schedule three or four of traditional medicine for the prevention and treatment of minor ailments. For example, a person with *mukhuswane*, or the 'common cold', can utilise steam inhalation to reduce or relieve the symptoms (Mulaudzi 2020).

The role of traditional health care practitioners in health care promotion and disease prevention

Traditional health care practitioners are the indigenous knowledge holders and in most cases first point of contact when an indigenous person needs primary health care services. Traditional health care practitioners play a primary role in disease prevention, protection and cure (Rankoana et al. 2015). Health care promotion is viewed as crucial in the prevention of diseases, as it entails promoting health care through performing traditional rituals and practices. Some traditional health care practitioners use 'bones' called *marambo* or *thevhele* in Tshivenḓa, *tinhlolo* in Xitsonga and *ditaola* in Sepedi. These 'bones' are used to communicate with ancestors who will guide or reveal how to care for their clients and families. In their practice, they usually use natural resources such as herbs, roots, seeds, corms (bulbs) and powder and sometimes mixed with water and animal products such as bone, teeth, fats and burnt skin (Thornton 2009). Most African families, whether rich or poor, have their traditional health care practitioner who takes care of the whole family. Some families perform rituals such as *u vhea mudi* in Tshivenḓa, *go thekga motse* in Sepedi, *go tiisa lelapa* in Setswana, *ku bhiya muthi* in Xitsonga and *ukubiya umuzi* in isiZulu. This act supports and protects the family from the invasion of diseases and is still practised by many families today (Rankoana 2019). If the designated family traditional practitioners are unable to care for one member of the family because of the limited knowledge of the condition(s), they consult those who have expertise in the treatment or prevention of the disease or refer patients. Disease prevention and health care promotion are practised by both the young and old. As such, among the Basotho and AmaZulu, there are certain practices performed by traditional health care practitioners which are believed to play a major role in health care promotion and the prevention of diseases in young children. In these cultures, a newborn baby is treated for *ibala*, *rigoni*, which is a red mark on the back of the head (Mulaudzi 2020; Waweru 2019). A known and trusted traditional

health care practitioner specialising in young children's illnesses will be asked to treat the baby to prevent the child from being a slow learner or even dying at a young age. The traditional health care practitioner will burn some dried herbs, and the baby will inhale the smoke, and incisions and marks will be made. The belief is that after this procedure, no bad luck will befall the child.

According to Zimba and Tanga (2014), other traditional practices followed by traditional health care practitioners include the throwing of bones to examine the sickness. Mothibe and Sibanda (2019) indicate that apart from healing the mind, body and soul, traditional health care practitioners have other roles, which include counselling, social mediation and community education. The authors go further to indicate that traditional health care practitioners are also regarded as the overseers of African traditional customs and beliefs. Another role includes issuing African traditional medicines (ATMs) with instructions regarding how to take their herbs or roots and sometimes where these roots can be found (Mothibe & Sibanda 2019).

The role of indigenous practices in health care promotion and diseases prevention

Use of traditional chores and practices in health care promotion

In African communities, both males and females, especially in rural areas, plough their fields to plant vegetables and maize. This is called *u lima masimu* in Tshivenḓa, *ku rima masimu* in Xitsonga or *go lema* in Sepedi. Indigenous unrefined maize, called *mavhele* in Tshivenḓa or Mavele in Xitsonga or *mabele* in Sepedi, is ploughed and harvested, thereafter grinded by females, which is called *u tohola mavhele* in Tshivenḓa or *ku tlhokola mavele* in Xitsonga or *go šila mabele* in Sepedi. The above-mentioned activities promote blood circulation and make the body strong, as they also form part of exercises. In the long run, cardiovascular and endocrine conditions are prevented, and the socio-economic status of families is also improved because some of the maize meal is sold (Health System Trust 2014). Ojua, Ishor and Ndom (2013) indicate that wrestling is another way to promote exercise among the Igbos, the Binis and the Ijaws in southern Nigeria and helps keep their bodies healthy and fit when it is not the time for farming.

Use of dance in health care promotion and disease prevention

Participation by females and males in traditional dances such as *tshigombela*, *malende*, *tshifasi*, *tshikona*, *muchongolo*, *xifasi*, *xibelani*, *xigubu* and *xincayincayi* promotes unity, teamwork and the spirit of *ubuntu*. As a result, stressful

conditions that might be caused by psychological problems are avoided and prevented. Traditional dances that are also a form of exercise aid in the prevention of non-communicable diseases (NCDs), which affect 60% of people. A study conducted in Uganda indicates that 33% of people die because of NCDs, for example, cardiac diseases, including diabetes mellitus. These conditions are of public concern and also affect South Africans; hence, traditional dancing is believed to prevent the occurrence of such conditions because of burning calories and improving blood flow (Kimani, Mayer & Swiderska 2020).

Another traditional activity that helps in disease prevention is when adolescent girls are initiated into adulthood through a school called *u imbelwa* among VhaVenḓa or *ku khomba* among the Vatsonga. This activity promotes reproductive health through the prevention of teenage pregnancy (refer to ch. 4). Sheppard and Broughton (2020) reveal that community involvement in music and dance has a positive effect on the health of people and is a key important factor in the promotion of health care and disease prevention. Historically, music and dance were regarded as an instrument to facilitate healing and good health. Active involvement in these cultural, social activities is beneficial in improving and maintaining the well-being of members of the community, hence enhancing the quality of their lives.

Traditional Zulu cultural forms of human movement, for example, play, martial arts and dance are still practised, mainly in the rural communities of South Africa, and these are associated with life and health care promotion (Hlongwane, Edwards & Roux 2007). During Zulu dancing, males *amabutho* and maidens *izintombi* perform the dance energetically and happily. Females and males are grouped according to their preferences with some involved in singing while others are clapping and others are whistling as a form of encouragement to those who are dancing. In their dancing, males will show their hunting skills combined with battling movements. They will also make loud noises by banging their shields and sticks. The AmaZulu females dance quietly, whereas those who are married will be ululating as they stare at those who are dancing, which has a downward directedness that ties the dancer to the life-giving energy of the earth. This collective movement energy is regarded as providing sustenance and strength. In this regard, the dancers are encouraged to continue with their dance; hence the communal spirit of working together is enhanced through the rhythm. According to Douka et al. (2019), dance is described as a series of steps and movements that match the speed and rhythm of a piece of music. The benefit of being involved in dance is improvement in body posture. Proper posture is said to improve overall balance and, generally, there are positive effects on the body. In addition, when the bones are positioned correctly, they improve the functioning of vital organs such as the heart and kidneys, and the muscles, joints and ligaments. Good posture makes the nervous system work to its optimal level with sharp thinking and reasoning, while it is also vital for proper health and overall well-being of a person.

Use of indigenous vegetables and maize meal in health care promotion

Indigenous dietary subsistence crops and vegetables are nutritious; hence their consumption plays an important role in health care promotion and disease prevention (Rankoana et al. 2015, Steenkamp 2020). See indigenous vegetables outlined in Chapter 13.

Thanga in Tshivenḓa, or *Tinh'wembe* in Xitsonga, known as *curcubita pepo* in English, gave birth to traditional pumpkins known as *mafhuri*, which can be cooked and eaten as is. The females peel the pumpkins and cook them as *thophi* in Tshivenḓa, which gives the body energy as it contains sugar. Found inside the pumpkin are seeds that are dried and fried and then eaten as a snack or with maize meal. The seeds are said to contain properties that help to improve urinary tract functions and prevent cancerous conditions of the stomach, breast, lungs, prostate and colon (Nishimura et al. 2014).

As indicated under the activities, the grinding of maize meal results in indigenous maize meal called *mufumbu* and *vhukhopfu* in Tshivenḓa, and also by Vatsonga. Maize, when cooked, is eaten as porridge (*mutuku* and *vhutete*) and can be eaten with insects such as *mopani* worms, locusts or *morogo* (indigenous vegetables). This provides the body with starch and serves as a source of energy. The starch found in the maize meal also promotes digestion and prevents constipation. Among the VhaVenḓa, *mavhele* (dry corn kernels) can be cooked to make what is called *mathuthu*. Samp is eaten with beans called *nawa*. *Phonda*, *nduhu* (peanuts) and ground peanuts can be added to samp and beans to make *tshidzimba*, a traditional dessert (cake) that is rich in protein and starch. This can be eaten as it is, and other people eat it as breakfast with tea. This food provides the body with energy and boosts the body's immune system, which plays a significant role in the prevention of infections (Nishimura et al. 2014; Pilane 2016).

Health care promotion through indigenous fruits

In a case study conducted among the Makanye community in Limpopo, it was discovered that traditional fruits are nutritious and are a primary source of body strength that plays an important role in disease prevention (Rankoana et al. 2015). However, a study conducted in Uganda and Kenya revealed a decline in the consumption of indigenous wild fruits, which leads to malnutrition in children (Kimani et al. 2020). The researchers recommended the consumption of indigenous foods, which would lead to a reduction in NCDs and malnutrition in children because of the high nutritional value they contain (Kimani et al. 2020). Indigenous fruits like *thanzwa* or *sourplum*, *tsuma* (*Vangueria infausta*), *thungulu* or *num-num, nombela* or *lychees* and *habu* (watermelon) contain vitamins C and D, which protect our bodies by enhancing

the immune system and assist in preventing conditions such as colds and influenza (Kimani et al. 2020; Mbhenyane et al. 2016; Sengupta 2017). Lychees and watermelons are recommended for the water they contain, which aids in hydrating our bodies during hot days and preventing constipation. Another benefit of lychees is weight reduction, which reduces the risk of NCDs. Lychees also help in the building of strong bones and prevent arthritis, fighting ageing and regulating blood pressure (Sengupta 2017).

Sour plum is found in most African countries such as Botswana, Kenya, Malawi, Mozambique, Tanzania, Uganda, Zambia, Zimbabwe and South Africa, and the roots are used in the prevention of sterility in females. Indigenous fruits are nutritious, and some contain vitamins and minerals which are essential for growth, prevention of disease and promotion of health care, as outlined in various fruits mentioned under this sub-heading.

Health care promotion through edible insects and indigenous animals

Edible insects such as *mashonzha* or mopani worms, *nzie or tinjiya*, known as locusts, *nemeneme, nthwa, nthwamakhura, maduhwi'swidongodi* and *majenje*, *madzhulu* or termites are highly rich in protein and fats. They can be taken as a snack or with porridge, and they contain properties that protect our bodies from worn-out tissues and provide energy and warmth. Protein from these insects helps in the prevention of malnutrition and is used traditionally in the prevention and treatment of Marasmus and Kwashiorkor. Nevertheless, traditional foods are jeopardised because of the consumption of various new types of food. Hence, their consumption would lead to the prevention of malnutrition, as they are rich in protein, minerals and vitamins (Kimani et al. 2020).

Taboos, cultural transgression and disease prevention

Numerous indigenous practices and beliefs are of the view that transgressing cultural practices or taboos is one of the ways people could become sick. According to Rankoana et al. (2015), mental and spiritual illness could be prevented by performing cultural sacrifices and observing taboos. Taboos are described as a vital part of the African traditional religion or a way of life that is prohibited by a group of people. Furthermore, taboos are labelled as social or religious customs restricting certain practices or relationships (White 2015).

Compliance with the rules stipulated by each culture played a role in the prevention of diseases and health care promotion. In African countries, traditional or indigenous practitioners believe that complying with taboos, even when a person is alone, not seen by others, prevents people from being

sick (White 2015). If a person does not obey the cultural practices, even when alone, that could be detrimental to their life or community (White 2015). In countries like Ghana, taboos can come in the form of food and meat, where a person is forbidden from eating certain foods and meats. Although all of these are named taboos, they have some moral and ethical implications for the people involved or the community (White 2015).

In South Africa, among VhaVenḓa culture, some of the cultural practices, like talking to an adult while standing, are forbidden; a child must sit down to show respect and doing so promotes a good relationship between a child and elders. Another taboo is that if, when walking down the road, one happens to come across some money, especially silver coins, then one is not supposed to pick up or pass over that money, as it is believed that the money was thrown after it was used to perform a ritual by a traditional healer to remove diseases from the owner of the money (Mulaudzi 2020). As such, it is believed that the person who picks up that money will be infected with the same diseases the owner was treated for. Similarly, a person is not allowed to sit in front of the entrance or door of their house, known as *u dzula kha tshi u khuvha*. It was believed that disregarding this would cause that person to develop an abscess on the buttocks.

In Zimbabwe, the Shona people use taboos [*zvieraera*] as one of the ways of teaching and encouraging conformity to healthy living among young members of society (Mambanga 2019). One must not leave cooked soup overnight without putting charcoal into it. It is believed that if that is not done and someone eats the soup, the person will get sick and die. In science, charcoal is significantly known to have the properties of absorbing the carbon content of liquids and thus preventing the action of micro-organisms. As such, the soup with added charcoal can stay overnight without going bad (Mambanga 2019).

Another taboo in Zimbabwe among the Shona people is singing while bathing. The folk explanation for this is that the mother of the person who sings while bathing will die mysteriously. The scientific explanation for this taboo is that soaps used in the olden days contained very acidic substances, and they were poisonous when swallowed in large quantities. The taboo was aimed at protecting people from the harmful effects of the poisonous soap (Mambanga 2019; Rankoana 2019).

Also, historically the Shona people believed that a widow or widower must not be present at the cemetery for the burial of their spouses. This was associated with the disruption of the smooth separation of the dead from the living and the departure of the dead to the world of spirits. It was believed that the ghost of the dead spouse would visit and take the soul of the living spouse away at night. This taboo had a psychological explanation in that it was meant and aimed at protecting the mental health or emotional well-being

of the living spouse. The emotional effects of the separation of spouses were considered to result in mental trauma or death of the living spouse (Rankoana 2019).

Values of taboos

Taboos are developed or created as a means of controlling people and society; they also serve as a means of integrating and uniting people from the same cultural background so that they can behave in a way acceptable to all (Osei 2017). It is made clear that disobeying the taboos meant inviting the wrath of the ancestors. People are therefore forced to obey and avoid violating the stipulated taboos. A person who is found guilty of not obeying the stipulated taboos requires some ritual cleansing to be purified (Osei 2017; White 2015).

Role of traditional/indigenous practices in rehabilitation

Traditional or indigenous practices play a vital role in the rehabilitation of patients. This can be done by a traditional family health care practitioner or a traditional health care specialist who revives patients from various sicknesses to their normal healthy selves. Various African countries have different rehabilitative practices, though there are some similarities. For instance, in Ghana, if people were treated for a certain illness and after treatment they did not get better or the condition grew worse, an animal was killed or buried alive to restore the soul of those about to die. It is believed that the soul of a dog is stronger and, as such, it can be used as a sacrifice to revive the dying person (White 2015). Another way of rehabilitation is thorough cleansing, where the blood of a slaughtered animal is used to wash a sick person so that the person is completely healed. Herbs can also be used for the same purpose, where they are mixed with water and used to wash the body for several days (White 2015). In South Africa, among Vatsonga, some rehabilitative practices include when children are recovering from measles or *ximungwamungwani*, they are bathed in a clay pot called *xirhengele* with water mixed with red soil called *tsumani* to hasten recovery (Lebese, Netshandama & Shai-Mahoko 2004). The clay pot is then broken at crossroads when the child recovers.

For the period that children are still sick of measles, they are isolated and cared for by elderly people, and access to the child is limited to those who are believed to not be sexually active. Siblings, especially those who never suffered from measles, are allowed to come into contact with the sick child and be infected for them to become immune (Lebese et al. 2004).

Some patients have more trust in traditional health care practitioners, for example, those suffering from human immune deficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) or tuberculosis (TB) and are

reluctant to continue taking medicines given at the hospital or clinic. As such, upon discharge, they go and consult the traditional health care practitioners for rehabilitation. Some traditional health care practitioners then ask the patients to bring the medicines they were given at the clinic or hospital upon discharge. Unbeknown to the patients, the tablets are crushed and given in a powder form. They are then instructed to mix the powder with soft porridge and take it until the end of the planned treatment period. Even those patients who default on their treatments are treated in the same way when they present themselves for consultation.

Referral system in traditional practices

In some African cultures, people believe in traditional health care practitioners more than they do in conventional medical doctors. Many families prefer to take their sick relatives to their trusted traditional health care practitioners first before taking them to the clinic or hospital. The traditional health care practitioner is the one who will then refer the patient to the clinic or hospital. Some traditional health care practitioners even accompany sick patients to the hospital and hand the patient over with all relevant information regarding their illness. Referral of patients, called *khokhai* in isiZulu, is important if the condition is not improving. If the patients were treated several times without signs of improvement, they are referred to another traditional health care practitioner who specialises in that condition. The same applies to traditional family health care practitioners. If they feel that the condition needs the expertise of another traditional health care practitioner, they will make the referral (Mabena 2020). Some traditional health care practitioners admit patients into their homes, and if there is no improvement, the patient is then transferred to the clinic or hospital. However, the management of patients at the clinic or hospital is different as they do not refer patients to traditional health care practitioners. However, some patients ask for a leave of absence to consult an indigenous practitioner if the condition is not improving.

Akol et al. (2018) indicate that traditional health care practitioners consider biomedicine to be limited in its approach, as it addresses only the physical causes of disease; however, some do refer patients to biomedical clinics. The referral of patients to hospitals and clinics is accompanied by various challenges, that is, traditional health care practitioners getting no feedback. Zimba and Tanga (2014) highlight that some traditional health care practitioners indicate that they do refer patients to the clinics where appropriate, but the same does not occur in reverse. According to Akol et al. (2018), some traditional health care practitioners assess and manage a patient three times, after which, if the patient is not better, they refer them to a clinic or hospital. Nevertheless, patients referred by traditional health care practitioners are not easily welcomed by some health care practitioners. According to Van Niekerk et al. (2014), traditional health care practitioners in South Africa, like in other African

countries, do not receive referrals from health care practitioners. The same applies to traditional health care practitioners in Kenya who do not get any referrals from health care practitioners (Akol et al. 2018).

According to Krah, De Kruijf and Ragno (2017), traditional health care practitioners in Ghana cross-transfer patients, and they exchange knowledge and experience. Traditional health care practitioners in the country started a 'traditional medicine information centre' where they refer patients from one traditional health care practitioner to another, they disseminate information and sell traditional medication. The same traditional health care practitioners have designed a digital database with contact details and names of other traditional health care practitioners, traditional midwives and health care practitioners from the nearest clinics and district hospitals. There is evidence of working relations between traditional health care practitioners and health care workers. What happens in such cooperations, when there is a need, is that the hospital will send patients to traditional health care practitioners after conducting some assessment, for example, an X-ray, where the traditional health care practitioners will read the X-ray and manage the patients. At the same time, the traditional health care practitioner can refer patients who are bleeding excessively to the hospital, where they will transfuse blood, insert a drip and manage the patient's pain. Traditional health care practitioners are then allowed to visit the patients they have referred to the hospital and talk about the management and treatment of complex patients with the doctors (Krah et al. 2017).

Challenges faced by traditional health care practitioners in primary health care settings

Name-calling or labelling

Although 60% of the population utilises the services of traditional health care practitioners, healers that are found with the skins of a crocodile called *ngwena* are labelled as witches among Maswati and VhaVenḓa (Mabena 2020). According to Zimba and Tanga (2014), some communities and some faith believers label traditional health care practitioners as evil worshippers possessed by evil spirits; and as witches called *muloi* in Tshivenḓa or *unmthakhathi* in isiZulu.

Unregulated practices

In most countries, even though traditional health care practitioners are recognised, they are not regulated. This becomes a challenge as there are false traditional healers who consult in the name of true traditional health care practitioners, hence tainting the good name of those who are honest, resulting in all of them being labelled as fake (Mabena 2020).

Lack of recognised practice facilities, stigma and government involvement

In Namibia, traditional health care practitioners are said to be faced with challenges of a lack of facilities to perform their practices, stigma associated with being a traditional health care practitioner and many suspected of practising witchcraft. The traditional health care practitioners in the country are also said to be faced with challenges of the dominating western health care sector, the disappearance of medicines because of bush encroachment and the lack of trust among younger generations. According to Zimba and Tanga (2014), some of the facilities in the Eastern Cape province are faced with the challenge of poor governmental collaboration, with the situation being precarious and extreme. Zimba and Tanga (2014) further indicate that traditional health care practitioners in KwaZulu-Natal are experiencing a similar challenge of lack of support and recognition from the provincial government. Traditional health care practitioners face challenges, including their reputations being questioned and the absence of well-grounded methods to assess the treatment they provide, which undermines their credibility and casts doubts upon the trustworthiness of their profession.

Lack of collaboration with other health care professionals

Although traditional health care practitioners are recognised all over the world, there is still a lack of collaboration between their practice and the health care system. In South Africa, there is little formal collaboration between allopathic and traditional health care practitioners despite discussions and recommendations made about the need to include them within the health care system. However, the DoH is of the notion that there must be a collaboration between the western health care system and the traditional health care practitioners in the first level of care (primary health care services), especially in the prevention and education of HIV and AIDS. The DoH does not advocate for referrals from the allopathic health care system to traditional health care practitioners, because their medicines are not controlled. Apart from that, there is no uniformity in traditional health care practices, especially when it comes to diagnosis and treatment.

Also, there is neither education nor scientific evidence of the effectiveness and efficiency of traditional medicines (Amole 2012; Van Niekerk et al. 2014). Akol et al. (2018) indicate that traditional health care practitioners believe that clinicians disregard them and are not prepared to work and associate with them as they are considered unclean and untidy with poor educational backgrounds. In the Eastern Cape province, traditional health care practitioners feel that the DoH is not willing to work with them, although they have the same goal of

improving the health care of citizens. The department is not willing to accept assistance from traditional health care practitioners in preventing the spread of diseases; therefore, traditional health care practitioners feel undermined. On the other hand, traditional health care practitioners fear collaborating with the DoH as they are afraid that their knowledge will be appropriated to advance western knowledge (Zimba & Tanga 2014).

Lack of support and lack of recognition

Zimba and Tanga (2014) indicate that traditional health care practitioners in Uganda face challenges of not being assisted, and as such, they are unable to sustain suitable standards of care. It is noted that traditional health care practitioners are not equipped with the knowledge needed to collaborate with the modern health care system. From a legal or governing framework, traditional health care practitioners face challenges that hinder the establishment of a council to govern and regulate their practice. Currently, traditional health care practitioners face challenges of not being officially recognised and not authorised to give their patients evidence of consultation in the form of a sick note. Educated traditional health care practitioners cannot receive funding to conduct research related to indigenous practices. Further challenges faced by traditional health care practitioners include condemnation from health care professionals who consider their practice to lack the information needed to bring it in line with healthy standards of hygiene maintained and observed by western practices (Zimba & Tanga 2014). Dlamini (2020) is of the view that although indigenous practices started long before contemporary medicines and made us who we are today; they are not taken into consideration by the majority of health care practitioners, such as nurses and doctors. These professionals overlook indigenous practices as they are moulded and shaped by the western ways of managing patients. Some health care workers even advise patients against visiting or consulting traditional health care practitioners.

Language barriers

According to Akol et al. (2018), another challenge perceived as an intrinsic barrier by traditional health care practitioners is their inability to communicate in English which is used by western health care provision. Also, health care professionals use it as a means to exclude the less educated traditional health care practitioners. Along the same lines, traditional health care practitioners fail to trust health care professionals.

Lack of traditional health care practitioners' registration

Mothibe and Sibanda (2019) indicate that even though the *Traditional Health Practitioners Act (Act 22 of 2002)* was enacted and inaugurated in 2013, there

has been reluctance from traditional health care practitioners to take up the registration. Several reasons for the drafting of the act are, for example, to establish an interim Traditional Health Practitioners Council, to provide for the registration of traditional health care practitioners and to categorise them as *sangomas*, herbalists, traditional birth attendants and surgeons. Other reasons included promoting education, training and execution of traditional practices, proposing the development of educational and training institutions for traditional health care practitioners training which will be accredited, to afford them the means to be reimbursed by medical aid schemes for services provided to patients including the mandate to give sick notes (Mothibe & Sibanda 2019).

Non-compatible, diverse health care system

Mothibe and Sibanda (2019) indicate that traditional health care practitioners shared their readiness to learn and refer patients to the health care systems such as clinics and hospitals. Nevertheless, their challenge is that conventional health care professionals do not share the same sentiment and indicate that the quality of health care will be compromised if traditional health care practitioners are allowed to practise at public health care facilities. Therefore, insufficient knowledge regarding ATM seems to be a major barrier to opportunities to collaborate (Mothibe & Sibanda 2019). Regardless of this, Mbatha et al. (2019), indicated that South Africa is still coming to terms with issues of integration of traditional medicine into the conventional health care system. However, there has been notable progress in the integration of traditional medicine into the legal framework by initiating the *Traditional Health Practitioners Act 22 of 2007*.

Lack of training

Although the *Traditional Health Practitioners Act 22 of 2007* has introduced the inception and setup of training institutions, to date, there are no formal institutions for traditional health care practitioners to be trained in South Africa. All traditional health care practitioners' training is undertaken by experienced healers and the training is unique to each prospective candidate. Another challenge is that there is no curriculum to date at various universities related to traditional practices. Before 2017, it was discovered that only one medical school out of the eight in the country had included African traditional practices and medicine in their curriculum, regardless of the calls made by the government to introduce concepts of traditional medicine in education and training (Mothibe & Sibanda 2019).

According to Zhandire et al. (2021), there is a disparity in traditional health care practitioners' practices, and there is no formal training offered. The act was aimed at regulating the registration, training, conduct, as well as licensing of traditional health care practitioners. However, up to now, the regulatory

framework process is yet to be executed. The authors continue to indicate that no pre-planned content for accreditation has been made to date. Falling into a pre-planned context means that the council cannot regulate the practices and accredit traditional medicine (Mbatha et al. 2019).

Challenges associated with cultural diversity

Krah et al. (2017) indicate that in Ghana, health care professionals and those who just completed their studies rendering community health care services have poor insight and understanding of the communities they serve. Graduates tend to discourage patients from using traditional medicine. As such, they influence their cultural beliefs, practices and health care practices on patients. Biomedical health care employees link traditional medicine with being impoverished or not keeping up with the latest developments. As such, patients are discriminated against and denied biomedicinal care at the mention of traditional medicine. Temporary appointed staff members and graduates on internships undermine the established relationship between healers and biomedical health care staff. Another challenge faced by traditional health care practitioners in Ghana is the lack of the means to practice traditional medicine (Krah et al. 2017). Finding traditional medicine making use of herbs and plants is a challenge because of the increasing population and the use of land for development. As such, traditional health care practitioners have to travel long distances in search of herbs and plants, and this causes a delay in treating patients and, in some cases, may lead to complications (Krah et al. 2017).

Unavailability of patient recording systems

Zhandire et al. (2021) indicate that despite the significance of documentation of patient health care information, there are fewer records with details of patients' health care information in traditional African health care practices. In South Africa, various ways were devised to incorporate traditional health care practitioners in the fight against HIV and AIDS. However, because of the lack of recording systems, the role they played is untraceable. For the two different health care practices to work, traditional health care practitioners will have to come to terms with recording and reporting systems on patient care. Zhandire et al. (2021) further state that the government should offer support by creating a governing body for the traditional health care practitioners' practices to be controlled and regulated in the same way as western health care practices.

Recommendations

The South African *Traditional Health Practitioners Act 22 of 2007* was developed to regulate traditional health care practice, but to date, the act has

not been implemented. This has resulted in the lack of recognition of practising traditional health care practitioners and the lack of established institutions for formal training. The collaboration between the two systems is vital for offering comprehensive services to patients. Recognition of traditional or indigenous practices in primary health care will aid in adopting safer practices and correcting unsafe practices. The identified good practices need to be infused into the curriculum of higher education and training so that health care professionals know and understand these practices to promote their use.

Conclusion

Various indigenous African practices, activities, rituals, taboos and foods are still utilised by many people and communities on the continent. These indigenous practices are believed to be beneficial to the health care status of people by protecting and preventing diseases from affecting their bodies. Most of the ATMs in the form of herbs, roots and leaves used in indigenous practices are readily available, easily accessible and efficient with fewer side effects. It is recognised and acknowledged that many people utilise both the indigenous and the western medical health care systems, with most consulting their traditional health care practitioners before consulting with the medical health care professionals. Despite this fact, traditional health care practitioners still face many challenges in their practice, such as lack of recognition and unfair discrimination within Western health care practices.

Glossary

- ***Artemisia*:** Also known as *thiumbeumbe*, it is utilised by African people as a steam inhaler in case one has flu symptoms.
- ***eucalyptus paniculate*:** Also known as *mubomo*, it is inhaled as steam for the upper respiratory system, like *Artemisia.*
- ***ibala/rigoni*:** Red marks or rash on the back of a newborn's neck
- ***ku khomba/u imbelwa*:** An activity performed by females where a female child is initiated after puberty.
- ***marabo*:** known as ancestral bones used by traditional health practitioners to assess, diagnose and treat patients.
- ***u lima masimu*:** An activity completed by both males and females which includes planting and ploughing maize meal
- ***u tohola mavhele*:** Also known as grinding maize meal is another activity that promotes and prevents diseases performed by females

Chapter 3

Wearing of artefacts for preventive and promotive care: An African indigenous practice of *go thekga* during infancy

Masetopana E. Ramaube
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Moselene A.R. du Plessis
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Ramadimetja S. Mogale
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

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Abstract[1]

The African health care system is considered part of their cultural heritage, which has been assimilated over the years and has been passed from one generation to the next. This chapter focuses on the wearing of artefacts as an African indigenous practice of *go thekga*, where babies in infancy (from birth to twelve months) wear artefacts to prevent diseases and ward off evil spirits who can affect their being (physical, emotional and spiritual). This chapter provides knowledge and understanding of (1) the types of artefacts worn by infants and the different beliefs attached to the artefacts, (2) the purposes of the artefacts and (3) healers who provide artefacts. In certain societies around the world, artefacts are worn by infants for disease prevention and health care-promotion. Hence, it is imperative that the health care professionals based in health care settings have knowledge and understanding of such artefacts and for them to provide culturally competent care to these infants as they are constantly in contact with the children throughout infancy.

Health care and cultural heritage

Artefacts are objects that signal the essential dimensions of lived realities, as they are seen as the assets of life that account for the culture and social processes of communities (Rowsell 2011, p. 334). Artefacts that are worn by infants are not only acquired from *isangoma* and *inyanga* but also from the indigenous knowledge holders (IKHs), some of whom are part of the infant's heritage. Infants are very young offspring who can barely walk and are aged between zero- and twelve-months-old. In this chapter, 'infant' refers to any human neonate between the ages of zero- and twelve-months-old (Rikhotso 2017, p. 10). It is the responsibility of *isangoma* and *inyanga* to perform the traditional practices in infancy. The intention of putting all the different types of artefacts is to protect and strengthen the infant's resilience to protect them from contracting diseases: *bana ba a thekgwa* [the infants are protected]. *Go thekga* as an African indigenous practice implies protecting a person to prevent diseases and ward off evil spirits that might affect their being (physical, emotional and spiritual). *Go thekga* is a practice that is usually performed by the traditional family healer in indigenous African families. Depending on the circumstances, the traditional health care practitioner might perform *go thekga* for the family on a yearly basis or when there are specific events in the family, like births. Many rituals and indigenous practices, like the provision and wearing of artefacts, are followed as a means of *go thekga* [to protect].

1. Sections in this chapter represent a substantial reworking (more than 50%) of Masetopana E. Ramaube's 2018 Master of Nursing (MNur) thesis, titled 'Traditional disease prevention practices performed during infancy in a designated municipality ward in Tshwane District', with study leader Prof. R.S. Mogale and co-study leader Prof. R.N. Ngunyulu, Department of Nursing Science, Faculty of Health Sciences, University of Pretoria.

The acquisition of the artefacts goes with the conducting of disease prevention practices in African indigenous societies. Wearing of artefacts as part of disease prevention and health care-promotion practices has developed over many centuries and is still practised in many different parts of the world (Hassim, Heywood & Berger 2007, p. 300). Mukoko, Cooil and Bart (2015, p. 225) indicate that such practices existed long before colonisation and continue to outnumber biomedical health care practices. According to the *Traditional Health Practitioners Act* (Act 22 of 2007, p. 6), these practices, among others, include the performance of activities, processes, services and functions that underpin traditional philosophy. The practices are about the utilisation of traditional medicine or traditional practices to maintain and restore the physical or mental health function of African people. According to the Act, these include the diagnosis, treatment and prevention of physical or mental illness and the rehabilitation to enable the person to resume normal functioning within the family and community. The practices performed in infancy differ from one ethnic group to another. However, in some cases, the rituals performed are common and applied to get the same outcome.

Emic-etic knowledge of health care professionals on African indigenous health care-promotion rituals

Health care professionals, especially nurses in primary health care facilities in Africa, need to approach African indigenous practices such as wearing artefacts from both 'etic' (outsider) and 'emic' (insider) stances. The two stances clarify the positions that are held by the health care professional regarding African indigenous practices. The etic perspective refers to the explanations for the behaviours of an outside observer in ways that are meaningful to the observer (Polit & Beck 2021, p. 475). In this case, the health care professionals might not have the knowledge and the existence of the practice; however, they are to have an open mind without any preconceived ideas (Bell 2010, p. 93; Naaeke et al. 2010, p. 1) about the indigenous practices or African ways of living. Concurrently, through the emic stance, the health care professionals are to see *go thekga* from within instead of interpreting through the references of other societies. In this instance, the health care professionals will acknowledge the knowledge and the practices and recognise the existence of the collective memory.

The two standpoints are unavoidable for health care professionals who render western health care services to the African majority that goes through *go thekga*. African indigenous practices such as *go thekga* demand commitment (Bell 2010, p. 94) as they are about dissecting, integrating and looking beyond the multiple viewpoints. Moreover, the etic-emic continuum compels health care professionals to become aware of who they are as African beings (Owusu-Ansah & Miji 2013, p. 3). Africanness becomes a reality if the

etic-emic viewpoints are honoured through the integration of the principles of indigeneity lens (Owusu-Ansah & Miji 2013, p. 1). Owusu-Ansah and Miji (2013, p. 2), among others, allude that: (1) knowledge is holistic, cyclic and dependent upon relationships and connections to the living and the dead; (2) there are many truths, and these truths are dependent upon individual experiences; (3) the relationship between people and the spiritual world is important and (4) the land is sacred. The aforementioned principles might assist health care professionals' especially primary health care nurses as the first point of entry to many communities where they provide health care services. Primary health care nurses need to interrogate and understand *go thekga* as an African indigenous practice, especially the wearing of artefacts during infancy.

Through an indigenous lens, the wearing of artefacts during infancy as an African indigenous practice can be traced to the reciprocal relationship and connection that African people have with the dead. 'The relationship between the living and the dead' is embedded in the African belief system (Ekore & Lanre-Abass 2016, p. 369). Such a relationship is the core (re)presentation of who the African indigenous people are; the living must appease their dead to maintain peace and harmony in their lives. Concurrently, the dead exert their influence on the living and their destiny (Mulaudzi, Mogale & Masoga 2018, p. 243). The dead in the African belief system continue to exist after corporal death (Ekore & Lanre-Abass 2016, p. 369). The wearing of artefacts in any period of life strengthens such relationships.

Wearing artefacts during infancy has many *experiential truths* from the African indigenous perspective. African people wear artefacts for different reasons in their lifespans from as early as infancy. The artefacts symbolise different issues in accordance with the person's beliefs and ancestral and family lineage (Miller 2002). Additionally, the practice of wearing artefacts illuminates African people's spirituality. In African spirituality, the ancestors and God reside in our beings as the twosome are responsible for the well-being of all beings (Eliastan & Buqa 2018, p. 138). Eliastan and Buqa (2018) further cite African spirituality as the *lived religion* that allows confluence, unlike the institutionalised religious tradition.

Furthermore, the wearing of artefacts explains the *sacredness of the land.* This is clearly explained through the different *totems* that African people worship from the world of fauna and flora around them. Different parts of these animals and plants are used to make different types of artefacts that are worn even during infancy as a way of honouring and respecting their (fauna and flora) existence.

Types of artefacts worn in infancy

There are different types of artefacts that are worn in infancy to practice *go thekga*, including spiritual and cultural or ancestral artefacts.

Spiritual artefacts

African spirituality refers to experiences of connectedness with *sacred beings* as well as the way of being through relationships with others, nature and life (Ramanand 2016, p. 7). Lydon Lam (2012) adds that spirituality is about the content of the belief system and is significantly linked to experiences and relationships with others. The available evidence indicates that not all artefacts are received from traditional healers; others are from the elders and spiritual healers. The spiritual healers are from African churches such as Zion Christian Church (ZCC) and apostolic churches, for example, St John. Most of these spiritual artefacts are in the form of white beads or cotton cloths of different colours. Usually, these artefacts are worn as charms on the arms, legs and waist. They were installed while the infant was still very young (Beşer et al. 2010, p. 138). During the process of putting them on, prayers are performed with the overall aim of protecting the infant from evil spirits and people.

Cultural or ancestral artefacts

By definition, cultural practices are a way of life and ways of doing things in a particular ethnic group. The practices are transferred from one generation to the other. The use of artefacts on infants is one such practice and is part and parcel of fulfilling cultural practices and cementing cultural identity. Cultural and ancestral artefacts are usually from the carcass of an animal or totem ('*phoofolo ye ba e binago*' ['venerate, uplifting the spirit of belonging, proclaiming dominance']), which is burnt and a small portion is taken to make the charm (Ramaube 2018, p. 46). The tribal totem is either a flora, fauna or animal that a clan or family venerates. For example, the Mamabolo clan venerates the warthog, the Letsoalo clan venerates the buffalo and the Makgoba clan venerates the elephant (Joubert et al. 2015, p. 466). The belief is that wearing such a charm in infancy will protect the infant from the same animal as a totem. Hence the infant is forbidden to walk where the totem passed. Additionally, most ancestral artefacts are worn for the promotion of the heritage of the clan or family name. It is reported that an ancestor might not approve of the name given to the infant, and in that case, the infant will cry a lot and not sleep at night (Ramaube 2018, p. 47). On consultation with the *iyanga*, the parents will be told that *ngwana o nyaka leina* [the child is crying to be renamed]. In African indigenous culture, ancestors play an important role throughout an individual's lifespan, starting from infancy. Hence some infants and children are sometimes referred as '*bana ba ba badimo*' ['children of the gods']. The wearing of specific ancestral artefacts by infants makes them easily identifiable in their communities.

Purposes for wearing artefact(s) during infancy as an African indigenous practice

Wearing of artefacts in infancy serves various purposes, such as protection from childhood illnesses, evil spirits, people using strong *muthi* and illnesses caused by unstable sunken fontanelle (*hlogoana*). If an infant does not acquire such an artefact during infancy, their life might be at risk. Various African indigenous people, like the Batswana and AmaZulu, believe that diseases and misfortune are linked to angry ancestral spirits (Bogopa 2010, p. 3). Others hold the belief that not all diseases come from ancestral spirits but are caused by a disbalance between nature and human beings (Adu-Gyamfi & Anderson 2019, p. 7).

In most of the ethnic groups in South Africa, the ritual called *imbeleko/mereko* is performed to welcome the newborn infant into the family and introduce them to the ancestors (Bogopa 2010, p. 5). After performing the ritual, whereby an animal such as a goat is slaughtered, a band is made from the goatskin and is tied around the wrist of the infant as a symbol of introducing and connecting them to the ancestors. The artefact of a wristband is known as *isiphandla* in isiZulu (Makunga, Thwala & Edwards 2011, p. 373). In Sesotho, the ritual is known as *hoananela*, which is performed using sheep or ox fat. This fat is tied around the infant's neck for some time (Opong 1997, p. 28).

In most cases, wearing artefacts during infancy is an African indigenous practice to guard and heal childhood illnesses, and for the protection from the totem as well as the evil spirits and people.

Prevention and healing of childhood illnesses such as *hlogoana* and *rigoni*

The words *hlogoana* and *inhlokwana* are used interchangeably by the people from Sotho and Nguni cultural backgrounds in South Africa. This, together with *rigoni*, is the main illness experienced during infancy. *Rigoni* is a red spot or mark on the occiput of an infant born of a mother with a sexually transmitted infection (STI). Rigoni is referred to by different names according to cultural and ethnic groups, which include *lekone* in Sepedi, *ibala* in isiZulu, *goni* in Xitsonga, or *abuntu* illnesses (Rikhotso 2017, p. 10), while in Tshivenḓa it is referred to as *gokhonya*. The infants suffering from these two diseases present with different symptoms such as fever, continuous crying, diarrhoea, vomiting, not sleeping at night and poor eye contact with the mother (Mulaudzi & Makhubela-Nkondo 2006, p. 49). Kindly view the chapter on STIs for a detailed description of *rigoni*. From the African perspective, some of these symptoms are associated with exposure to evil spirits, people using strong *muthi* and coming into contact with the infant and failure to please the ancestors (Elter, Kennedy & Chesla 2014, p. 5).

Protection from the *totem* (*moeno*)

Totems are the selected ecosystems, animals, plants, rivers and mountains, considered sacred natural elements that serve as guardian spirits (Diawuo & Issifu 2015, p. 117). In totem worship, certain elements of the ecosystem have a significant sacred attitude for a specific clan hence the (elements) are venerated. Usually, in African indigenous practices, the use and destruction of totems are forbidden among the followers. Hence it becomes taboo for clan members to eat or destroy such totems (Benson 2021, p. 21). The totem is usually identified through the praise poems or songs of the clan. Infants usually acquire artefacts from the carcass of such an animal (Benson 2021, p. 21).

Protection from evil spirits (*meleko*) and patients using *muthi*

Evil spirits have been established as another challenge that contributes to the ill health of developing infants. According to the African indigenous perspective, the infant might be exposed to evil spirits when it comes across different people who might be using strong *muthi* or even children and infants who are ill. The said artefacts ensure that the health of infants is not at risk and acts as protective measures (Ramaube 2018, p. 14). In some cases, *doepa*, a smelly, manufactured homeopathic medicine that consists of an offensive sticky substance, is considered to be highly effective in warding off evil spirits because of its strong scent. The *doepa* is prepared for infants in cases where several people are expected to visit the homestead for events or celebrations and is smeared on the fontanelle (*ukhakhayi*). This is considered a susceptible point where hazards such as evil spirits enter the child. This will be done to protect the infant from *meriti ya batho*, that is, the presence of unknown people around the infant, such as people who might have recent deaths in their families (Ramaube 2018, p. 51). In some cases, *doepa* is put inside the artefact that infants wear around their necks. Wearing an artefact made from *doepa* will also prevent the infant from having *makgoma.* According to Lekgothoane and Ross (2020, p. 3), *makgoma* is a culture-bound disease characterised by severe bloating and restlessness, which usually happens when the infant is in contact with those who have recently undergone an abortion, attended funerals or been possessed by evil spirits.

The healers who provide the artefact(s)

The World Health Organization (WHO) estimates that 80% of people worldwide are utilising the services of traditional medicines for different health-related problems (Burman 2018, p. 166). In Africa, this includes the utilisation of traditional healers, knowledge holders and healers from various religions. The services that are offered by these other healers are usually specialised. Among these specialisations are artefacts for infants for *go thekga*.

Priests and pastors as healers

Africa has a diverse landscape as far as religion is concerned. In conjunction with African spirituality, major religions among African people include Christianity, Islam, Hinduism and Judaism (Kubeka 2016, p. 8). Faith healers (*abathandazi*) comprise a sophisticated combination of traditional African religion and Christianity (Mlisa 2009, p. 186). From a Eurocentric perspective, *abathandazi* are faith healers and are known all over the world. In Germany, they are known as the *helpraktiker* (Stockigt et al. 2015, p. 1) and they mostly pray or lay hands on those who require healing, including infants. In the Muslim religion, faith healers are known as *imams*. Though the *imams*, like *abathandazi*, do not receive formal training in spiritual healing, they assist with various health care problems throughout the lifespan of a person. Mlisa (2009, p. 192) further explains that the connection of ancestors and the burning of sacrifices in the Old Testament are linked to most African indigenous rituals. Most of the artefacts that are worn by the infants are acquired from the Zionist and Apostolic churches where *abathandazi* practice. The *abathandazi* use spiritual energy (*umoya*) together with holy water, steam baths, purgatives and enemas as their healing methods. Munthali et al. (2016, p. 133) expound that after the performance of the rituals, they usually tie artefacts made of wool, cloth or beads of different colours, especially red coiled wool, on the infants.

Traditional healers: *[I]sangoma/ngaka/selaodi/vhomaine/mungome*

According to the WHO (1978), as cited by Shankar et al. (2012, p. 124), a traditional healer is defined as a person who is recognised by the community as a competent person to provide health care using plants, animals and mineral substances and other methods based on social, cultural and religious backgrounds as well as on the knowledge, attitudes and beliefs that are prevalent in the said community. The *Traditional Health Practitioner Act 22 of 2007*, Section 1 refers to a traditional health care practitioner as a person who is registered under this Act in one or more of the categories of traditional health care practitioners. The Traditional Health Practitioner Council, as a professional body established by parliament, gives registered traditional health care practitioners the authority to issue medical certificates in line with the provisions of the *Basic Conditions of Employment Act (BCEA) 75 of 1997* (Tshehla 2015, p. 267). The traditional healer is the name that is mostly used in various communities for different types of healers. Traditional healing is based on indigenous knowledge practised by generations of different tribes depending on the culture, religion or custom (Ekor 2013, p. 1).

In the case of artefacts in infancy, traditional healers are consulted by the parents to acquire relevant artefacts for the infant. In South Africa, the traditional health care practitioners are referred to as *ngaka* in Sepedi, *selaodi*

in Sesotho, *mungome* in Xitsonga and *vhomaine* in Tshivenḓa, also known as *izangoma* or *izinyanga* in isiZulu and *amagqirha* in isiXhosa (Truter 2007, p. 57). In South Africa, the *Traditional Health Practitioners Act 22 of 2007* recognises the legality of traditional health care practitioners and these include sangomas, diviners, herbalists, faith healers, traditional birth attendants and traditional surgeons (Republic of South Africa 2007, p. 6).

However, in general, South Africans refer to them as *sangomas*. According to Masoga and Shokane (2020, p. 315), sangomas 'consider themselves to be members of a profession with a distinct intellectual tradition, one that undergoes critique, modification and change in the light of experience and myriad influences'. Sangomas regard traditional healing as involving a quest for good quality of life and providing access to support and health care. According to Asamoah-Gyadu (2014, p. 83) and White (2015, p. 5), they commence by consulting the bones and interpreting the cause of illnesses and prescribing the cure, which might be a particular artefact that the patient, in this case an infant, must acquire. Additionally, they might prescribe herbs (*muthi*) that are relevant to cure or prevent illnesses or evil spirits by performing rituals.

While other parents use the sangomas to acquire artefacts for their infants, some consult the *inyangas* or herbalists (Kubeka 2016, p. 21), also known as *ixhwele* in isiXhosa (Truter 2007, p. 57), while in Sepedi they are referred to as *dingaka.* The herbalist uses herbs and other forms of traditional medicinal preparations to make an artefact. During the acquisition of the artefact, herbs are prepared and rituals are immediately performed on the infant. Thereafter, an artefact with *muthi* is made and tied to the infant. The parent is usually given treatment to take home, and these are usually a concoction of the herbs which they have to continue using at home.

Indigenous knowledge holders

Some artefacts are acquired from IKHs. These are the people who possess indigenous knowledge in their communities. According to the Protection, Promotion, Development and Management of Indigenous Knowledge Systems Bill (RSA 2016, p. 5), indigenous knowledge implies the knowledge that has been developed in indigenous communities and has been assimilated into the culture and has an essential character to that specific community. Among others, such knowledge includes (1) *scientific or technical knowledge*, (2) *knowledge of natural resources* and (3) *indigenous cultural expressions*. According to Okka, Durduran and Degerli-Kodaz (2015, p. 501), indigenous knowledge is generational and it is transferred from one generation to another. An IKH means a member of the community from which indigenous knowledge originates and is the custodian of sacred knowledge (Kwame 2008, pp. 28, 43). According to Popova (2005, p. 66), Kayombo (2013, p. 3), Gottlieb (2004, p. 16) and Du Preez, Griffiths and Cameron (2008, p. 3), globally, the informants

on the indigenous practices are usually senior females or grandmothers who are familiar with and have experience with the practices.

These grandmothers usually provide the artefacts and information to prevent, protect and cure diseases during infancy. The knowledge holders demonstrate to the mothers and caregivers how the artefacts are made. In New Zealand, such demonstrations are packaged by the IKHs as part of child-rearing practices (Jenkins 2011, p. iv). Most products that the IKHs use are teething beads, *serokolo*, *dupa* and *stuipdruppels*. These products are available at pharmaceutical outlets throughout South Africa (Moshabela 2012, p. cxi).

Discussion

Artefacts are the objects that signal essential dimensions of lived realities and are seen as the assets that account for the cultural and social processes of communities (Rowsell 2011, p. 334). The artefacts worn in infancy, in the African indigenous practice of *go thekga* are for different purposes and are obtained from different healers, as stated. However, all these are for *go thekga* in infancy as an African indigenous practice. Figure 3.1 is a pictorial representation of the wearing of artefacts as an African indigenous practice during infancy.

The artefacts are usually worn around the necks, wrists, legs and waists as part of the traditional preventive practices against evil spirits. The artefacts

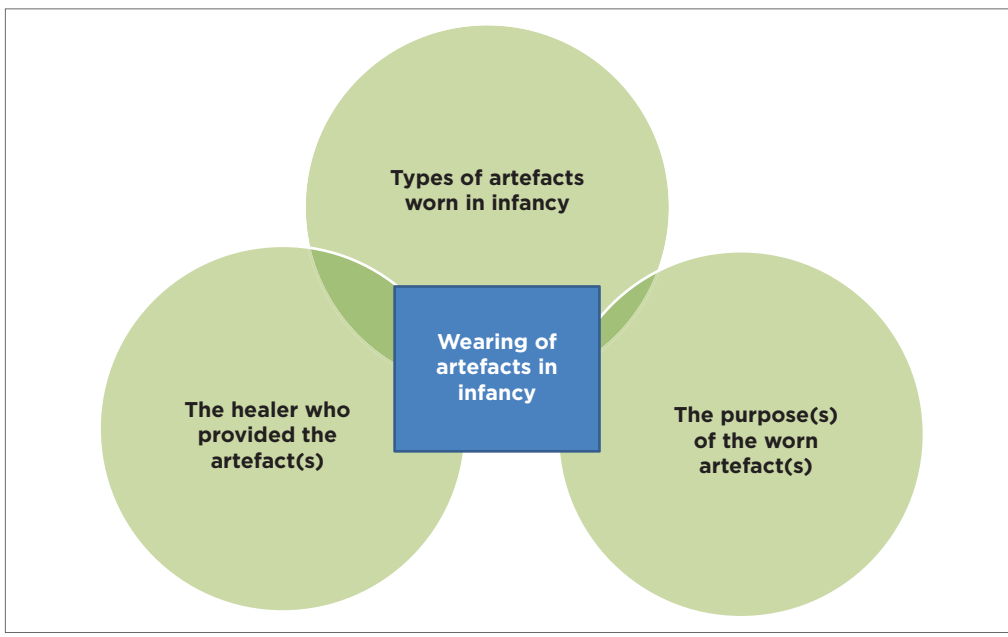

FIGURE 3.1: The pictorial representation of the wearing of artefacts as an African indigenous practice during infancy *go thekga*.

symbolised different issues and they are in accordance with the parents' belief system and culture. Most importantly, they are made of different materials such as wool, cotton material and beads of different colours. Wearing of artefacts is not only an African practice but prevails globally and is also used in South-East Asia in countries such as Thailand, where artefacts are worn as amulets (Armer 2014, p. 1; Srichimpa 2013, p. 49). Most people in these countries and infants wear these artefacts for religious purposes.

The wearing of artefacts around the different parts of the body is ascribed to the tradition and culture of the specific ethnic group. From an African indigenous perspective, healing is holistic and considers the physical, mental and spiritual processes of recovery, repair and reintegration that increase order, coherence and holism in the individual, group and environment (Phyllis 2008, p. 10). Healing may result in a cure. Explanation of healing in Aboriginal society is articulated as the means of mending bodies and souls, rekindling the flame that strengthens the spiritual as well as the physical, mental and psychological well-being (Fearns 2006, p. 11). In support, Kubeka (2016, p. 10) explains the African orientation of healing as everything being in spirit; the vital life forces known including the extrasensory the energy and consciousness, gods and guards and appearing materially as the five senses. For African children to experience this wholeness, parents frequently visit traditional health care practitioners, and this starts with a consultation shortly after birth to acquire artefacts.

The parents acquire artefacts from the different healers and this is supported by Popova (2005, p. 65), citing that a newborn baby is much more susceptible to the influences of various supernatural forces and spirits of illnesses; hence most treatment methods are based on this understanding. From an African perspective, for healing to occur, one must be at peace with the ancestors, as they are the ones that offer infinite protection (Mekoa 2020, p. 45).

Infants without these recommended artefacts, in most cases, present with different symptoms such as fever, diarrhoea, vomiting and not sleeping at night. These symptoms are associated with exposure to evil spirits, people using strong *muthi* and failure to please their ancestors (Elter et al. 2014, p. 5). As part of the tradition, when an infant presents with these symptoms, a specific artefact is prepared for them to wear.

Implications of the study

The findings of this study urge the recognition of the co-existence of two healing practices (allopathic and traditional) for the health care and well-being of infants. The co-existence is supported by a WHO (2013, p. 15) document on traditional health care practices, as it was noticed that some of those community members rely on both allopathic health care and traditional health care services for their survival. Additionally, the findings highlighted

the role of traditional health care practitioners as the most preferred and easily accessible to the community. The health care facilities such as clinics and hospitals are faced with the challenges of a severe shortage of personnel. The integration of traditional health care practitioners into the current health care facilities might address current challenges.

Biomedical health care professionals should have frequent reciprocal workshops with IKHs and traditional health care practitioners on comprehensive health care and wellness topics and practices relevant to the lifespans of African people.

Conclusion

The main purpose of this chapter was to provide knowledge and understanding of the types of artefacts worn by infants and the different beliefs attached to such artefacts. This includes understanding the rituals and processes that are followed to acquire such artefacts, and how wearing artefacts prevents disease and promotes health care in infancy. Different types of artefacts are worn by the infants as part of *go thekga* an African indigenous practice. The artefacts are intended to prevent, protect and heal infants from common illnesses. For the infants to acquire the artefacts, a healer of choice – an IKH, priest/pastor or traditional healer – is consulted. The healer will then perform rituals as part of the process to tie the artefacts to the infant. Most of the artefacts do not have a time frame assigned and are worn until they naturally fall off. Of importance is the fact that the artefacts worn depend on the ethnicity and belief of the parent(s). The artefacts seen are evidence that most Africans still use this African indigenous approach for their infants' physical and social well-being.

Glossary

***abathandazi*:** Faith healers
***badimo*:** Ancestors
***bana ba ba badimo*:** Children of the gods
***ba thekga bana ba bona*:** Strengthens the infant's resilience from contracting diseases
***dupa/doepa*:** Protection from evil spirits
***go thekga*:** To protect
***hlogoana*:** Small head or sunken anterior fontanelle
***imbeleko/mereko*:** Celebration
***isiphandla*:** Wristband
***ixhwele*:** Herbalist
***meleko*:** Evil spirits and people using *muthi*
***moeno*:** Totem

***makgoma*:** A culturally-bound illness characterised by severe bloating and restlessness
***meriti ya batho*:** Presence of unknown people around the infant
***muthi*:** Traditional herbs
***ngwana wa badimo*:** Ancestors' child
***ngwana o nyaka leina*:** Correct naming of the child
***rigoni*:** red spot or mark on the occiput of an infant
***sangoma/ngaka/selaodi/vhomaine/mungome*:** Traditional healer
***stuipdruppels*:** Mixture for effective relief from flatulence, gripes and colic
***ukhakhayi*:** Fontanelle
***umoya*:** Spiritual energy
***ye ba e binago*:** Venerate, uplifting the spirit of belonging, proclaiming dominance

Chapter 4

Rite of passage: An African indigenous knowledge perspective

Rachel T. Lebese
Department of Advanced Nursing Science,
Faculty of Health Science, University of Venda,
Thohoyandou, South Africa

Tebogo M. Mothiba
Department of Nursing Science,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa

Mercy T. Mulaudzi
Department of Psychology,
Faculty of Health Science, University of Venda,
Thohoyandou, South Africa

Ntsieni S. Mashau
Department of Public Health,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa

Lufuno Makhado
Department of Public Health,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa

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Abstract

A rite of passage is an event or ceremony practised within different cultural groups, especially among indigenous African people, to mark an important transition in life. It is an important stage that is celebrated at birth, the transition from childhood to adulthood, and during more stages. For example, in males, there is the circumcision ceremony known as *lebollo* (among Bapedi), *ulwaluko* (among AmaXhosa), *ngoma* (among Vatsonga), *bogwera* for males and *bojale* for females (among Batswana), to name a few. This chapter describes the different rites of passage that indigenous African people practice marking the different stages of life. The chapter also describes the characteristics and the processes followed when these rites are being implemented. There are different types of rites of passage that indigenous people in Africa practice. The rites of passage are based on the notion of sharing life and vision with the community, which is rooted in the mystery of life and death. Again, these rites of passage are practised and performed based on age and health status. Therefore, health care professionals need to know the rites of passage practices of the communities they serve. This will enable them to understand the people they serve and be of assistance where possible. The different types of rites of passage practised in different cultural contexts in Africa are discussed concerning their impact on the health care system.

Rituals and symbols

Various rites of passage are celebrated in different ways within African cultural societies. These symbolise a time when there is change at an individual, community or cultural level. The rite of passage can be a ceremony by performing a ritual when an individual leaves one group to join another or an experience that marks or constitutes a significant milestone or a change in a person's life. It involves a substantial change in status and involves how an individual is viewed in society.

Rites of passage can take different forms, which can be any of the following: reproduction, the achievement of manhood and womanhood, marriage, death, birth, and more. The most common rite of passage practised by most cultural groups is the one that marks the entry into adulthood for both girls and boys. It is viewed by most indigenous societies as an important stage in life and is embraced with pride. The purpose of this chapter is to discuss the rites of passage within different cultural contexts and how these impact the health care of the African societies practising them.

Definition of a rite of passage from an African perspective

Parents and community members are involved in the rite of passage, which facilitates the healthy transition of the individuals. As the individual's status in

the family and community changes, the experience is said to be transformative (Blumenkrantz 1996). According to Mandova, Mutonhori, and Mudzanire (2012), the African rites of passage involve human development through life stages such as birth, adulthood, marriage, eldership, and death. Rites refer to ceremonies, while passages refer to the transition between developmental stages (Warfield-Coppock 1992).

Separation, transition, and incorporation are the three characteristics of rites of passage. The separation process involves being away from home and a change of routine. This is where human development begins, and there are physical changes and a shift from childish behaviour to adulthood. Puberty, for example, is characterised by uncertainty and mystery, which can cause anxiety. During this time, the individual is experiencing human emotions that can cause extreme stress. A course of ethics and values training guides the conduct of the initiate. As the children grow and mature, they move to the incorporation phase, where the internalisation of values, norms, and ethics is learned during the transition.

Norms and values, which an individual internalises, guide them in the expectation of living well within the community and demonstrate their acceptance as emerging adults (Turner 1968, 1987; Van Gennep 1960). According to Kasomo (2009), there are several different rites of passage classes, including territorial passages, private and public passages, marriage and betrothal rituals, and funerals. The rite of passage plays an essential role in the developmental stages of African people.

Stages of rites of passage

Rituals and ceremonies associated with rites of passage typically fall into one of three categories (Falanga 2021):

- The first step is toward something new that involves the separation from familiarity and social structure. One gradually gets closer to the unknown to learn and acquire new skills.
- Liminality refers to the point at which a person crosses the edge or margin of society. In other words, it can refer to the period between two stable conditions or stages of a person's life.
- The process of reintegrating involves putting what has been learned into practice in an individual's daily life. As the person returns from the edge, it is a new role or identity that they assume. Individuals who re-formulate an understanding of life learn to develop and accept themselves better.

In précis, each ceremony has a beginning, middle and end. The space 'in-between', also known as 'liminality' or 'threshold', is essential (Markstrom & Iborra 2003).

The role of the rite of passage

The rites of passage also have educational value because of the emphasis on fostering positive attitudes. Rites of passage are based on the notion of sharing one's life and vision with the community, which is rooted in the mystery of life and death. The rites of passage play an important role in the life cycles of African societies. Pregnancy and childbirth are regarded as a passage from the spiritual to the physical life (Warfield-Coppock 1992). Different African tribes celebrate childbirth according to culture. Rituals are performed to celebrate and welcome the newborn baby to the family and ancestors. Also, sexual life in African society is viewed as important and is connected to the origin of life and procreation as a means of continuity.

Puberty is regarded as a passage from childhood to adulthood and is celebrated accordingly. The rite of passage to adulthood is celebrated differently according to gender. Boys are initiated into adulthood through circumcision and other cultural rituals. The role of the rite of passage among Masaba ethnic groups in Uganda is described by Kasomo (2009) as a form of relationship that is formed between the living and the dead, where often a male person is granted a status. It is believed that the initiate has a relationship with the ancestors and God, who is the ultimate ancestor. The rite of passage educational theory promotes a people-centred approach to life, which is gradual and experimental to transform the initiate from an inferior position to a higher status (childhood to adulthood). It is characterised by an initiated radical change in thinking, feeling and doing, and the basis of this change is a new worldview (Kasomo 2009).

The following is a summary of the role of the rite of passage in the individual and community:

- Initiation introduces the initiate to communal living, where he is withdrawn from his family to go and live with other initiates in the forests. This is done to conscientise the initiate about his new role before he can rejoin his family and community. It is a symbolic experience of death, which relates to the process of dying, living in the spiritual world and being reborn.
- Rejoining the family is a rebirth, and the initiates have become new as they have acquired a new personality and are given a new name.
- Initiates are introduced into adulthood, where they are given new privileges and challenges within their families and communities.
- Initiates are introduced to adult life, the life of the living, the dead and the life of those still to be born.
- Initiation exposes the initiates to information such as sexual life, marriage, procreation, and family responsibility.
- Rite of passage has an educational purpose as initiates are given the information they did not have access to. It is an end to infancy marked by the socialisation of various issues.

- Endurance is emphasised as the initiate is expected to learn to live with another, keep secrets, have relationships with the opposite sex and always be courageous when met with challenges (Kasomo 2009).

According to Warfield-Coppock (1992), marriage is regarded as a passage to communal and interdependent life, and eldership is regarded as the stage of wisdom. All these rites of passage are viewed and embraced by communities and individuals and are important when introducing someone to be a responsible and respected member of the community. Death is regarded as a return to spiritual life. According to African traditions, death is regarded as a transition to ancestorship, and different cultural rituals are performed to celebrate death and introduce the dead person to the ancestors.

Characteristics of rites of passage

Blumenkrantz (2009) has identified 20 characteristics of the rite of passage as reflected in Table 4.1.

TABLE 4.1: Twenty characteristics/elements of rites of passage.

Component	Definition
1. Paradigm shift	In contrast to being seen solely as a psychological phenomenon, adolescent development can be viewed as part of a broader community development process. Adolescent interventions are ecological, not individual.
2. Community values and ethics	To develop community-based rites of passage strategy, it is essential to create intentional, inclusive dialogues about what are the values and expectations that young people must uphold so that the community can succeed. For these discussions to occur, deliberate structures must be put in place to facilitate reaching some agreement about fundamental expectations for behaviour and values. Before introducing youths to these expectations, experiences must be created to nurture their understanding, appreciation and involvement.
3. Programme success relies on relationships	Positive outcomes are possible only when people are intimately involved in creating and adapting the strategies. A strategy can be only implemented with enough commitment and creativity to succeed if implemented with the buy-in of everyone.
4. You can only bring someone as far as you have been yourself	If the key to youth's coming of age is relationships, initiators must be trained and develop their skills to build their awareness and resources. During their transition to maturity, trainers must undergo their rite of passage and initiatory experience by which they will initiate the youth.
5. It must happen in the home community	Local communities and real-life interpersonal interactions define the type of community children grow in. It is critical for children to feel a sense of belonging and security when connected to an actual geographic place, incredibly when close to nature. By creating safe places for intentional conversations between community members, the rites of passage are created a safe environment.
6. Rites of passage create expectations for socially appropriate behaviours	As part of the rites of passage ceremony, parents and communities are responsible for developing environments that transmit essential values and ethics that guide and inform how socially appropriate behaviours are to be exhibited.
7. Rituals	A ritual is a set of actions performed regularly. When a ritual is part of a rite of passage, it can set a tone and impact the school's climate to foster an atmosphere of learning.

Table 4.1 continues on next page→

TABLE 4.1 (cont.): Twenty characteristics/elements of rites of passage.

Component	Definition
8. Adversity or personal challenge	People tend to learn new values or skills through experiences that challenge them emotionally and physically.
9. Silence	It is almost impossible for children and young people to hear the internal alarm clock as they come of age amidst the cacophony of sounds. Silent individuals can develop an internal dialogue to describe and understand what is happening around them.
10. Stories, myths or legends	Moral or cultural lessons from previous generations are passed down through stories.
11. Connection with nature	Through experiences, individuals become aware of their interconnectedness and dependence on the natural environment.
12. Time alone for reflection	A specific period is set aside for reflection on one's values, actions and beliefs.
13. Connection with ancestral roots	It is an opportunity to learn and appreciate one's ancestors and their values and ethics.
14. Play	Finding your 'bliss', those activities you can do with passion and bring unrestrained joy.
15. Giving away one's previous attitudes, behaviours, etc.	By participating in rites of passage, people give up or away from certain aspects that marked their previous status, for example, behaviour, attitude, and cherished items. It emphasises on change – letting go of the past – as a necessary part of the transition.
16. Non-ordinary states of reality	Playing 'in the zone' while doing sports and hobbies to experience the non-ordinary state of reality.
17. Obligation to service to the larger community	Adolescents participating in the initiatory process are taught that community service is integral to becoming fully functioning adults in society.
18. Changes of appearance that express/reflect the new status	Initiates may adorn themselves with an external symbol representing their transition into a new status. As part of public rites of passage, a person might receive unique clothing, accessories, badges, etc.
19. Opportunities to demonstrate new competencies and status	As part of the rite of passage, participants can publicly demonstrate newly acquired skills and status.
20. Celebration of status	The recognition and acclamation of the new status of initiates are done through community celebrations.

Source: Blumenkrantz (2009).

Rite of passage practices in different African cultures

According to different cultures, African societies observe various life stages such as birth, adulthood, marriage, the elderly and death by practising rites of passage.

Rite of passage during pregnancy and childbirth: African indigenous perspective

African lifestyle is based on the belief that communities live together and are intertwined. It is characterised by the sharing of knowledge on various issues to promote communal life. The traditional indigenous way of life involves working together for the common good, and this also involves childbirth.

Therefore, it is important to understand the role of indigenous knowledge among females during motherhood and childbirth (Siwila 2015).

Giving birth is celebrated through ritual events in which the whole community is involved. It is rejoiced by husband, wife and family, and thanksgiving is offered to appease the ancestors (Nwadiokwu et al. 2016). Motherhood defines a female and is regarded in high esteem, and the consequent inability to give birth is always depicted negatively. Consequently, should a female experience miscarriage, she is called 'one whose basket leaks' and the one who does not conceive is called 'the one who ate the placenta'. It is noted from these statements that the womb is an important organ as it is meant for nurturing and celebrating life (Siwila 2015). Among the South African Vatsonga people, the females who do not give birth are called *mhika* – or *muumba* in and *moopa* in Sepedi. Females who cannot conceive are often discriminated against, as it is alleged that females have conducted many abortions. The naming of barren females in African indigenous cultures shows how these females are discriminated against and the high status given to females who have children (Siwila 2015). Females who bear children are respected in all cultural groupings, unlike the barren females who are oppressed and ridiculed in their communities. They are viewed as having brought this on themselves and are called names. Often these females are left without psychological support and may experience anxiety and depression.

The rite of passage for pregnant females

The transition of expectant females from conception to childbirth is celebrated through different rituals. Some of the rituals have dietary restrictions as it is believed that it is going to ease the delivery. Among the Vatsonga, pregnant females are not allowed to eat eggs or significant portions of food because they believe that the females might have difficult labour. The female is not allowed to sleep, especially during the day, as this is believed to cause laziness in the unborn baby and might cause difficult and slow labour. Within the same cultural group, pregnancy is not announced to many people; only a few people can be informed about the pregnancy as it is thought that the unborn baby might be bewitched. The female is also expected to follow certain customary norms, ethics, and standards (Siwila 2015). This is also observed in Akamba and Gikuyu (Kenya), where pregnant females observe regulations and taboos, including wearing protective amulets and avoiding doubtful foods. In Kenya, among the Abamba clan, pregnant females are forbidden to eat food originating from animals, beans, and meat. Among the Ika (Nigeria), the females are permitted to eat anything as advised by elders (Nwadiokwu et al. 2016). The rite of passage by pregnant females has three stages which are (Van Gennep 1960):

- **Separation:** In which the person relinquishes social status.
- **Transition:** When the person fits into the new role.
- **Incorporation:** When the person integrates this new role.

In Zambian cultural practices, during the ritual of separation, the pregnant mother is separated from the community for the child's safety. It is believed that the pregnancy must be handed over to the ancestors, who become the custodian of the pregnancy. Separation is done early in pregnancy before other people take notice and is done by the family for fear of attack from evil people; this ritual is called *kwagga da* among the Tongas in Zambia (Siwila 2015). This ritual announces pregnancy among the living and the dead, and the white herb stringed beads are tied to the female's waist and wrist as protection from the evil spirits. Pregnant females are advised on how to dress, what to eat and other prohibitions related to sex life. After this, the pregnant females are treated differently as they are detached from the community among the Bemba people. This is called *balipakali*, which means 'midpoint', and the one who lives between life and death with an unknown future. This phase is characterised by personal ambiguity, non-status, and un-anchored identity; however, psychological support is offered to the female. The unborn child is not given a name as it is believed that naming a child can cause evil attacks on the unborn baby (Turner 1967). When the baby is born among the Bemba people of Zambia, people are greeted by the following words *mwapusukeni* (Sherwin 1998).

The naming rites are of significance among African people and are celebrated. The naming ceremony takes place a few days after birth. The nursing mother does not cook for a full three months. She is served special food rich in venison. Only after three months, both the infant and nursing mother allowed to go to the market (Nwadiokwu et al. 2016). During separation, the mother is also said to be in-between unclear spaces; the mother and the child are allocated a separate house away from the rest of the family. The couple is separated to protect the child from contamination because of the father's promiscuity, which can affect the father–baby bonding. Collaboration among females is enhanced as females in the community are available to support the new mother (Oduyoye 1992).

Rite of passage and motherhood

Females undergo different phases as a form of rite of passage during pregnancy, which addresses their health and well-being. Females are assisted in dealing with the event that has already occurred and others that are still to happen. New responsibilities and values are learned and embraced (Oduyoye 1999). Among Akamba and Gikuyu in Kenya, births occur in the female's hut or a special house constructed for the purpose. An elderly female would act as a midwife, and males and menstruating females are not allowed in the delivery place. Delayed delivery is ascribed to sorcery, witchcraft or sin on the part of the mother (Nwadiokwu et al. 2016). Mothers of children are respected in communities, especially those that gave birth to boys, as they are seen as having given birth to their heirs.

Rituals at childbirth

Childbirth is treated as a life cycle and communal event within African communities. It involves rites of passage such as birth and naming rites, involving nature, and the spirit world of the living and the dead, with the aim of community building (Siwila 2015). Within the Zambian culture, the disposal of the placenta is one of the most important events. In Tonga culture, the placenta is buried under the Mapundu (*Parinari curatellifolia*) tree, behind the hill, or at the centre of the hut. The burial site is significant to the mother, the child, and the clan. This burial is said to be in line with the child's rite of passage and signifies the importance of the placenta as a biological part of the child (Siwila 2015).

The communities believe that the child has a continuous connection to the placenta though separated, hence the ritual performance to relink them. This is emphasised in burying the placenta in the hut, which signifies that the child belongs to the homestead, especially if it is a male child. Should the children die, they are brought back to the homestead and it is said that 'let him/her come to lie where his/her is', which means where the placenta is (Siwila 2015).

The Mapundu tree is a symbol of the human connection to nature and its fertility. Burying a placenta under this tree is believed to evolve fertility within the female's womb to continue to be fruitful. The value of the placenta decaying under the Mapundu tree is of high importance. The tree's significance is also observed among Bemba people as, during initiation, a female child is introduced to the Mapundu tree by asking her to sit under the tree during initiation lessons (Siwila 2015). Vatsonga also buries the placenta in the cattle kraal within the homestead to cement the child's existence within the family. Different cultures have different rituals that are performed during childbirth, and this is viewed as one of the things that will protect the child and the mother from any bad occurrences that could occur in the future.

African indigenous communities have been practising the rite of passage for males since ancient times. This rite of passage concept has been transmitted from one generation to a generation. This rite of passage focuses on the traditional, spiritual and cultural context as practised within African cultures. This is viewed as a passage to manhood that involves initiation and circumcision. The community values and beliefs are reflected in these practices and passed on to the upcoming generation (Twala 2007).

Male circumcision

Male circumcision is defined differently among different cultural groups in Africa. Concepts that are used to describe male circumcision, include the following: *lebollo* among Bapedi, *ulwaluko* among AmaXhosa, *ngoma* among Vatsonga and *bogwera* among Batswana, to name a few. These concepts carry many cultural meanings within these different cultural groups (Phokane 2017).

Among the various African groups, circumcision involves the surgical removal of the foreskin; however, various initiation teachings accompany the surgery and hence carry a lot of meaning. The surgical removal of the foreskin marks the entrance into a new stage in life, and the initiate is expected to act and reflect the new status the young male has acquired (Phokane 2017). Circumcision among AmaXhosa is highly significant as it represents a transition from boyhood (*ubukhwenkwe*) to manhood (*ubudoda*) (Vincent 2008). According to the VhaVenḓa, male circumcision is one of the most important rituals in a boy's life; it is a rite of passage that makes him a man, allows him to hold status within the community and enhances his sexual capabilities (Dionisio & Viviani 2013). A circumcision ceremony in AmaXhosa and AmaZulu culture is described by Doyle (2005) as a rite of passage from boyhood to adulthood marked by bravery and sacrifice. The essence of bravery within circumcision is also alluded to in the work of (Niang & Boiro 2007) where bravery during circumcision is of importance as these boys should bear the pain of incision.

Circumcisions are practised in non-clinical settings and are overseen by a traditional practitioner, and they have different dimensions which can be religious, social, philosophical and biomedical (CSSR 2009). Among the Senegalese, circumcision is regarded as an important rite of passage that has a religious dimension. It is believed that circumcision comes from God and is sacred. The male is given the name *Njulli* which means prayer. It is expected of a circumcised male to pray and to meet the spiritual purity required for an act of religious communion. Circumcision is viewed as a sacrifice to the ancestors when blood is shed on the ground (Niang & Boiro 2007). The spilling of blood on the soil is viewed as an incorporation of the initiated personhood to their ancestors and the land, which is tied to the community where the young male is born. Consequently, the bond to the land and ancestors compels individuals who have migrated to return to their forefathers' land for burial, should they die (Ramose 2005).

Within the African perspective *lebollo*, *ngoma*, *ulwaluko* or *bogwera* (circumcision) for males is seen as a way of initiating young males to be effective role players in the sustainable and continuous existence of their societies (Maharasoa & Maharaswa 2004). The same authors further indicate that the preparation of young males for adulthood includes the following aspects: marriage counselling, sexuality education, herbology, and law and democracy, which give the rite of passage a holistic approach (Turner 1969). It is further believed that when an initiate has completed the rite of passage, the young male enters into a new relationship with their ancestors (Papu & Vester 2006).

From an African perspective, a circumcised male should have respect for societal values and norms. These norms and values are expected to be upheld and prohibit indulgence in petty crimes, such as stealing cows, which can be tolerable if done by uncircumcised males. It is also expected that initiated males exercise control over sexual desires (Niang & Boiro 2007). This shows how much emphasis is placed on the individual's change of character.

Therefore, it is expected that there be a distinction between an initiate and an uninitiated male based on their behaviour, where the initiated should behave well (Froneman & Kapp 2017). The initiate is taught how to honour and respect their ancestors by adhering to the customs. This is said to be a vertical relationship and, at the same time, have a horizontal relationship with the other initiates and females in general.

The rite of passage in males also brings up other responsibilities, such as the right to procreate and establish a family of their own (Papu & Vester 2006). It can be assumed that the African rite of passage for males offers them some form of leadership and responsibilities. Niang and Boiro (2007) describe what an uncircumcised male is called, which is derogatory. They are referred to as *nayafan*, which means the one who does not have responsibilities. Initiation offers a sense of belonging in the community, and males always aspire to belong.

The rite of passage for males is done at a time in his life when it is assumed that the boy is ready to take up responsibility. Among the Southern Ndebele people of South Africa, young males who are ready for initiation are referred to as *amaja*, and this is marked by placing a hornlike structure, which can be a reed or grass [*umshoso*], on their forehead for about a month, as an indication that they are about to go for initiation (Van Rooyen, Potgieter & Mtezuka 2006). This marks the passage of the individual from a lower status to a higher one. Should the initiate be too young, the young male is given such status as the mother cannot bathe them and cannot sleep in the same bed as females. It is assumed that the initiate has a relationship with their body and people of the opposite sex (Niang & Boiro 2007). Social relations are also fostered between initiates of the same age. These initiates are expected to develop a strong bond and be available for each other in times of need. This bond is stronger than that shared by parents, and initiates are also expected to display a great sense of masculinity (Mark 1997).

In certain cultures in Senegal, Guinea, and South Africa (Bapedi), circumcision is separated from initiation. There is an identified separation between circumcision and initiation, and failure to complete the second phase is deemed as not having completed the rite of passage (Mark 1997). The WHO (2009) reports on initiation practised among East and Southern African communities who do not practice male circumcision; for example, in Kenya, the six lower teeth are removed as a sign of a rite of passage. It must be noted that anyone who underwent traditional circumcision is more respected by the community than those who went through medical circumcision.

☐ The process of *lebollo/ngoma* (male circumcision)

The *lebollo/ngoma* (male circumcision) process has different stages: before the formal process, during the formal process, and after the formal process (Phokane 2017).

☐ Before the formal process

This is the stage that helps the initiates to prepare for the formal initiation stage. Some preparations are necessary to prepare the initiate for *lebollo/ngoma*. The parents are the ones that prepare their son for initiation. The prospective initiate is grounded spiritually to appease the forefathers and parents. The initiate is encouraged to be brave and not drop out before the process is complete (Phokane 2017).

The prospective initiate is encouraged to have good relations with his extended family and elders in the community. This is said to lay down good relations with them as they will support him during initiation. During this phase, the sacredness of *lebollo/ngoma* is explained to the initiates, including avoidance of sexual activities to prevent sexually transmitted infections (STIs) (Phokane 2017).

☐ During the formal process

The initiate is separated during this phase. Among the Southern Ndebele people, the period of isolation is from April to June, which is in the winter, as there is less risk of wound infection. Initiates are kept in secluded areas under the supervision of an elder appointed by the chief (Van Rooyen et al. 2006). During this phase, education is strengthened, which can be through direct instructions, small group work, problem-solving, role-playing, folklore, and metaphors. Initiates are introduced to new areas and given responsibilities as they are assisted in growth towards taking responsibility and accountability (Phokane 2017). This process takes place in the presence of a mentor (*Mudabe*).

☐ After the formal process

This is the time when the initiates return home. It is expected that the initiates will abide by the values that have been inculcated into their lives. The initiates are expected to apply moral principles, spirituality, and beliefs, execute leadership and facilitate health care promotion (Phokane 2017).

☐ Adverse effects associated with male circumcision

Circumcision is associated with a wide range of adverse events. The reason for this is likely to be because of several factors, such as the age of the child at circumcision, the provider's training and expertise, the sterility of the conditions in which the procedure is carried out and the indication (medical or cultural). Male circumcision in traditional practices holds a higher risk of complications, such as sepsis, genital mutilation, excessive bleeding, gangrene, septicaemia, and permanent disability from the complete or partial amputation of the glans or shaft, the formation of a skin bridge between the penile shaft and the glans, urinary retention, meatal ulcers, meatal stenosis, fistulae, loss of

penile sensitivity, dehydration (which may result in renal failure), sexual dysfunction and oedema of the glans penis (Mogaha 1996).

African indigenous rite of passage for young females

Among indigenous African communities, different rituals and events are performed to signify the right of passage from girlhood to womanhood. This event is marked by a celebration where young females are brought back to their communities and are expected to behave differently than before (Sotewu 2016). The rite of passage among young females is named differently among different indigenous communities of Africa; among others are *Intonjane* (among the AmaXhosa), *Vukhomba* (among the VhaVenḓa), *khomba* (among the VhaVenḓa), etc. The rite of passage for young females among African indigenous communities is practised once the the young female has had her first menstruation. Culturally, the young female is presumed to be ready for marriage after attending the rite of passage.

Most cultures incorporate these rites with ritual cleansing, physical transformations, offerings, prayers, blessings, traditional food, garments, instruments, and songs (Delaney 1995; Singh & Bhagwan 2020). Maluleke and Troskie argue that the rite of passage is a way for young females to maintain their virginity by emphasising social values (Maluleke & Troskie 2003). A young female is viewed as unimportant in their family and community before they are initiated. Delaney (1995) maintains that the rite of passage involves separation from society, preparation by an elder, transition into adulthood, and rejoining society.

Stage of separation

This is the first phase of initiation, which held secret and private and regarded as a closed process where the young females are prepared for adulthood. The young person dissociates herself from the community and family. This process is intense as the young female is involved in totality (intellectual, psychological, social, emotional and spiritual). It is expected that the young female will transform from their old self to a new self with a new role and purpose. Being a new person, the young girl also becomes strange to themselves. However, there is a need for the initiate to master their developmental tasks by altering their self-concept (Van Rooyen et al. 2006).

Young females between the ages of 12 and 20 can undergo the initiation process among the Ndebele people of South Africa. During this initiation, a girl would be given a new name to symbolise entering into a different developmental stage. Young females are isolated during this stage and are kept in their mother's hut, and they may only go out when they need to bathe, for example, at the river. Access to the hut is given only to the mother and aunts, who are involved in mentoring the young females. During initiation,

young females are exposed to two stages. The first stage lasts for about five to ten days after their first menstruation. The second stage lasts two to three months after their second or third menstruation (Van Rooyen et al. 2006).

The stage of threshold, restoration, and entrance

During this period, the initiate is waiting on the threshold of life. The young females are taught about the secrets of womanhood, such as hygiene and privacy, sexuality, childbirth, married life, and how to be a good mother and wife. The young female is expected to have self-respect, self-discipline, and be submissive. Correct feminine behaviour is expected; this includes the use of the right and left hands appropriately when eating. Sexuality and relationship with the opposite sex are encouraged. The young female can be friends with boys and exchange visitation from this time. The young females are also allowed external intercourse by not allowing a male to ejaculate inside their female body. Young females are also warned unplanned against pregnancy, as they are told that they will be married off to an older person or a male with many wives as a form of punishment (Van Rooyen et al. 2006).

The young female will make a symbolic entrance to the outside world on the last day. There will be festivities, where their friends will sing and dance outside their hut for the whole night. In the morning, when the initiate appears, the young girl is accompanied to the river, where she is expected to wash her body so that all the dirt can flow with the water and she will become a new person (Van Rooyen et al. 2006). Among all cultural groupings, *lebollo/ngoma* (rite of passage for young females) is conducted differently. Still, it is embraced, and people who have gone through that process are expected to know the importance of taking care of their families and also have respect for humankind.

African indigenous rite of passage and death

The rite of passage for death is one of the utmost important rituals among African people. Various death-related activities are performed either in the morning or late in the afternoon and differ from country to country. Death among indigenous African people is acceptable during the individual's ripe years; hence death that comes before ripe age is considered a bad death. The mourning takes a period that varies from one place to another and can take up to four months related to the first burial. The second burial may only be after one or three years of the initial burial (Van der Geest 2004). The stages of mourning an adult person can be differentiated into the following: the announcement of the death, preparation of the corpse for burial, lying in state, the interment, the rituals, feasting and ceremonies (Ademiluka 2009b).

Announcement of death

Among the Nigerian people of the Delta area, the passing away of an older person is marked by crying, wailing, weeping, and signs of the beating of the relative's breast. Similarly, the Igbo people mark death by loud crying and shooting of guns, while in central Nigeria, the death of an older person is announced by the wailing of females and children accompanied by cannon shots. In the case of a wealthy person, a drum is beaten to inform the ancestors of his coming (Gbenda 2005; Ifie 1982).

After the death of an older person, the Yoruba tribe slays a fowl called *adie-Iran* to make way for the process of moving to the ancestors. In case the person is transported, a live fowl is carried in front of the burial procession transport by a male walking and plucking its feathers until the area of destination is reached (Awolalu & Dopamo 1979). In each cultural grouping, there is a different reaction to death in the family or the community. The reaction is further differentiated based on the age group of the person who died, and the burial announcements are also different.

Preparation of the corpse and lying in state

As part of the preparation, the corpse is washed and dressed properly; if it is a male, the head is shaved, and the female's hair is plaited. In Nigeria and Sierra Leone, the corpse is rubbed with oil or camwood, the body is covered with indigo-dyed cloth, and the face is covered with a cap. This is accompanied by dancing and feasting with music, funeral songs are sung and money is spent. The deceased lie in that state for weeks until the corpse start to smell, depending on the cultural group (Awolalu & Dopamo 1979). In contrast, among the Tiv, the corpse is buried immediately within 24 h (Gbenda 2005).

The interment

The interment is done early in the morning and afternoon. In the olden days, people were buried in graves dug in the compound or the house for spiritual reasons; however, nowadays, graves are found outside the towns and villages. For some important people, sacrifices are made during the burial, for example, putting cola-nuts, animals, human beings, slaves, and food in the grave. This was done to ensure that the deceased could use these on the way as the destination is unknown. Females would be buried with their necklaces, earrings, clothing materials, food, and utensils (Awolalu & Dopamo 1979). In contrast, in the Tiv communities burying people with things was not practised, and it was believed that it might cause another death. When the coffin is lowered, people will throw a handful of earth on the coffin (Gbenda 2005).

During mourning, widows would sit on the barren floor without a carpet or mat covering, next to the coffin. They are not permitted to wear jewellery and are not permitted to leave the house for three months. In other instances, the widow would sleep on her husband's grave for three months or visit the grave three times a day. The widow cannot change her clothes and her hair should not be plaited or washed (Awolalu & Dopamo 1979). Among the Kumbuo tribe, mourning is conducted on the third or fourth day of the burial, marked by washing all clothes worn during the funeral. The bedding used by the couple is put away, and prayer is held for the husband to be the guiding spirit for the children (Ifie 1987).

Impact of adolescent initiation rituals

Several studies have examined the effects of adolescents attending initiation camps for weeks or even months as part of their rituals. Considering the disproportionately high incidence of HIV and AIDS in some countries, it is tempting to focus exclusively on modifying practices to look at HIV and AIDS exclusively. Several NGOs cite HIV rates as a motivating factor for concern and a rationale for change (Kamlongera 2007). However, focusing only on HIV and health care neglects the social and emotional effects on young people (Kamlongera 2007). Professionals and community members need to examine the physical and psychological impacts of initiation rites.

Some rites of passage have positive and challenging aspects, and it is a challenge to categorise them as exclusive positive, negative or neutral. The inclusion of lessons on sexuality demonstrates this. There are barriers to discussing sexuality throughout the country, making rites of passage ceremonies a positive development and a stage where sexuality education takes place (Kangwa 2011; Warria 2018). Despite this, the lessons are not adequate and inconsistently shared. Furthermore, without oversight, it is unclear whether the information is presented in a way that builds positive self-esteem and self-efficacy, as opposed to bringing negative gender stereotypes.

The adolescent rites of passage are not exclusively physical. Positive sexual decision-making and health care outcomes are related to social and emotional effects (Ethier et al. 2006; Van de Bongardt, Reitz & Deković 2016). It is not uncommon for young females to note that that they enjoy undergoing the rites of passage – being viewed as females and learning about sex and sexuality makes them feel empowered. Femininity, attractiveness and the ability to provide sexual pleasure to males are embedded in their values (Ekine et al. 2013). However, females, especially young females partaking in rituals, bring self-consciousness and embarrassment by being expected to dance partially or entirely naked in front of an audience (Padmanabhanunni, Jaffer & Steenkamp 2018). Furthermore, they may also have their menarche status discussed publicly rather than kept private.

As this chapter discussed, community members have contradictory feelings on the value versus the negative impact of various rites of passage. The positive impacts and rationales for adolescent initiation rites of passage rituals contribute to young people's identities and a more valued social standing in their communities. Generally, the impacts and outcomes of adolescent rites of passage within the South African context are more favourable for young males than young girls. Many rites of passage, although not all, have vital gender role components that are premeditated to keep males strong and females submissive.

Recommendations

Indigenous beliefs and values have a spiritual connection to health and wellness. Therefore, when admitting and caring for an indigenous patient or client, clinical health care professionals should take an approach that considers both spiritual and medical needs. Indigenous people's overall health and wellness are directly related to their balance and harmony on all levels, physical, mental, emotional, and spiritual. Unwellness may result from an imbalance between these levels, which could be alarming and troubling for them. Providing health care services to patients while integrating some understanding of rites of passage, spirituality and religion promotes wellness for them. For indigenous people, the integration or co-existence of Western medicine and traditional or indigenous medicine can be invaluable and allow them to reclaim their wholeness. It can also be emphasised that the promotion of Western health care approaches and rites of passage, when aligned, can promote good health care and wellness among community members. Although not all rites of passage promote health care, their understanding can help provide relevant health care education and promotion for all ages among traditional community members. With an understanding of the rites of passage, age-appropriate health care promotion can be targeted to a specific rite of passage to preserve healthy lifestyles and appropriate strategies for promoting healthy lifestyles and general wellness.

Conclusion

African indigenous people have different rites that they observe. As such, health care workers need to be aware of the significant changes and transitions in a person's life. Traditionally, these transitions were done consciously and with the whole community's support in the form of rituals, helping to form new identities and supporting adolescents' and young adults' mental health and well-being. These practices have different meanings in different cultures. Clinical care professionals must acquaint themselves with these practices to assist their patients or clients from an informed position. Such interactions must be rooted in respect for one another and established in a relationship of trust.

Glossary

- ***a rite of passage*:** An event or ceremony practised within different cultural groups, especially among indigenous African people, to mark an important transition in a person's life.
- ***death*:** Regarded as a return to spiritual life.
- ***initiation*:** Introduces the initiate to communal living, where they are withdrawn from their family to go and live with other initiates in the forests.
- ***liminality*:** The time when initiates return from the edge, and it is a new role or identity they assume.
- ***male circumcision*:** Involves surgical removal of the foreskin; however, various initiation teachings accompany the surgery.
- ***puberty*:** Regarded as a passage from childhood to adulthood, celebrated according to the different African cultural groups.
- ***separation*:** First step toward something new. Thus, one separates from familiarity and social structures and gradually gets closer to the unknown to learn and acquire new skills.

Chapter 5

Child spacing and prevention of pregnancy among African indigenous people

Rachel T. Lebese
Department of Advanced Nursing Science,
Faculty of Health Science, University of Venda,
Thohoyandou, South Africa

Tebogo M. Mothiba
Department of Nursing Science,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa

Mercy T. Mulaudzi
Department of Psychology,
Faculty of Health Science, University of Venda,
Thohoyandou, South Africa

Ntsieni S. Mashau
Department of Public Health,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa

Lufuno Makhado
Department of Public Health,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa

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Abstract

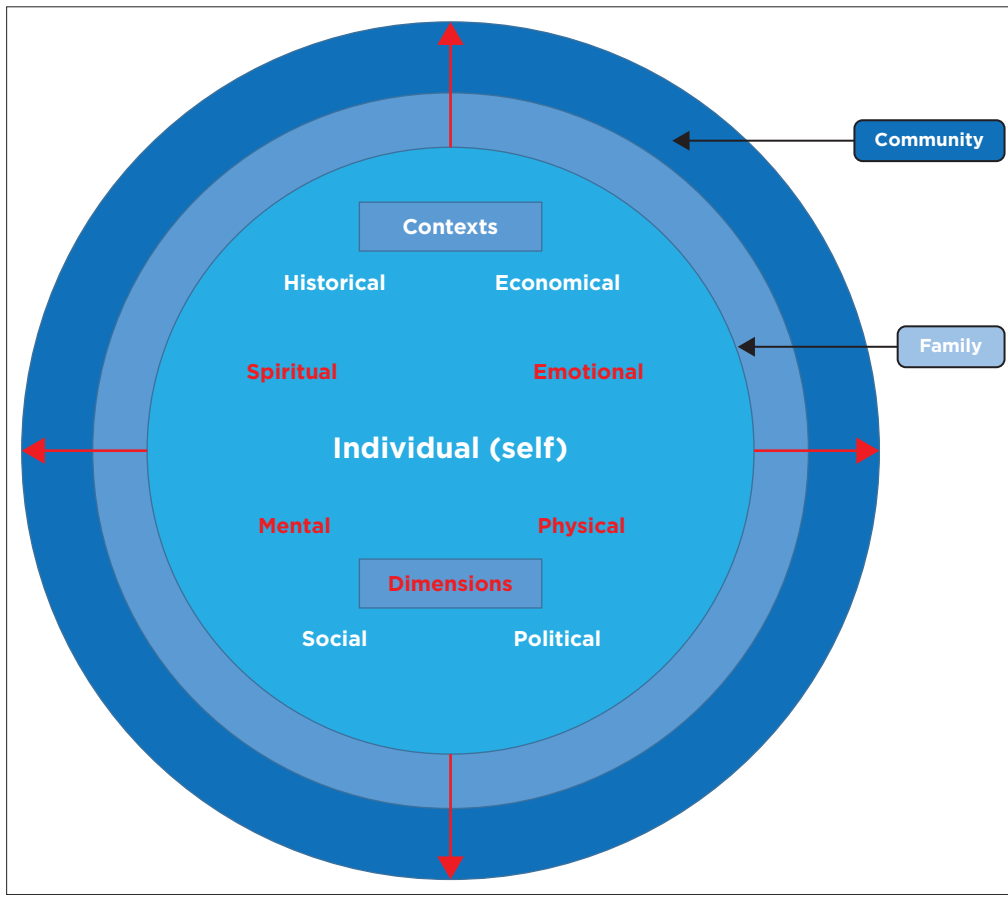
There are different family planning methods in modern medicine. However, literature shows that birth or child spacing and prevention of pregnancy among indigenous African people have existed since time immemorial. From time to time, mothers feel the need to space their children using indigenous methods. Literature shows that females, to prevent pregnancy and consequently space birthing their children, use different indigenous methods. These methods include breastfeeding, abstinence, *ukusoma* (thigh sex), withdrawal, moon-cycle checking, the calendar method, use of herbs and artefacts, and *u fhahea nowa* (a uterus environment preventing successful conception after some traditional medications are administered). Clinical health care professionals must know these indigenous methods to enable them to develop culturally safe health care plans that meet the needs of their clients. Emphasis should be placed on how good indigenous methods can be enriched while those harmful to the end-user are highlighted to make health care professionals aware and assist the end-users in making informed decisions. The documentation of indigenous child spacing methods will help promote appropriate, culturally safe and acceptable practices that will assist in the prevention of pregnancy. Sharing and documenting this tacit knowledge will promote the co-existence of both indigenous and Western approaches to improve child spacing and the prevention of pregnancy.

Pregnancy

The World Health Organization (WHO 2020) defined child spacing as 'the ability of individuals and couples to plan and achieve their estimated number of children'. The prevention of pregnancy can be achieved through using birth control methods, such as abstinence and natural and cultural child spacing. It should be noted all people of the world, including indigenous people of Africa, have practised child spacing using indigenous methods since ancient times. However, indigenous child spacing and birth control methods are under-reported and their effectiveness has not been fully explored as more emphasis is given to medical family planning and contraceptives. Mothiba, Lebese and Davhana-Maselesele (2012) conclude that many African females still use indigenous child spacing as a method of birth control. Mothiba et al. (2012) highlight the importance of health care professionals also addressing such issues when attending to patients seeking child spacing services. The authors go further to indicate that health care professionals have to reconcile indigenous and biomedical child spacing methods to provide appropriate care to their patients. The United Nations (UN) (2013) reports that about 5.4% of females, aged 15–49-years-old in sub-Saharan Africa, use indigenous methods as preventive measures for unplanned/unwanted pregnancies. At 12%, the use of indigenous birth control is said to be high in Central Africa. Among the indigenous birth control methods: abstinence, withdrawal, use of

plants and herbs, and attaching a string around the females abdomen are widely used (UN 2013). According to Rossier and Corker (2017), a lack of knowledge regarding indigenous child spacing methods leads to poor utilisation of the practice. As such, it is important to raise awareness of the indigenous child spacing methods among females of childbearing age.

This chapter is conceptualised within the indigenous wholistic theory (IWT) shown in Figure 5.1. The theory is characterised by drawing concentric circles and four directions based on the indigenous worldview that is anti-colonial and ecological (Absolon 2019). There are different levels of being, and these include the female, who is at the centre of the activity of a functioning family forming part of the community with reciprocal interconnections. This means that the family and, consequently, the community influence the individual's decision-making. This chapter emphasises the role played by self-determination, family and significant others in the decision-making about child spacing of individual females. Therefore, immediate family members are



Source: King-Absolon (2019).

FIGURE 5.1: A visual overall framework using a circle to summarise the indigenous wholistic theory (IWT) as a necessary knowledge set for practice.

involved in the process, and some decisions are made with or without the approval of the female involved.

Furthermore, a person's being is influenced by historical, economic, social and political contexts; and each of these layers is composed of a spiritual, emotional, mental and physical dimension, and these are interrelated and interconnected. Our realities are based on the connections and the interactions among these interrelationships and interconnections. Clinical health care professionals need to understand the different reality dynamics influences decision-making regarding child spacing and prevention of pregnancy to provide holistic care to individuals using indigenous child spacing methods.

In assisting female patients to meet their reproductive needs, health care professionals need to apply the *ubuntu* philosophy. This is where the interaction between health care professionals and female patients observe mutual respect, individualised holistic care, acknowledge and treat each other as equals, value each other's contribution and have healthy communication (Metz 2011). The most important aspect of the engagement interaction is to ensure that females take the lead in the decision-making process.

This chapter sheds light on the different African indigenous child spacing and pregnancy-prevention methods. It provides awareness to health care professionals to be responsible for female's health care services based on the indigenous wholistic theory and *ubuntu* philosophy. As indicated, there are different types of indigenous child spacing and birth control methods. Most people in Africa and other continents still use these methods. The methods vary from country to country and healer to healer. This chapter focuses on providing insight into the different indigenous birth control methods, which include abstinence, lactation amenorrhea, withdrawal, polygamy, weakening of sperm, use of herbs (plants, leaves and barks) and artefacts (Maliwichi-Nyirenda & Maliwichi 2010).

Indigenous approaches and practices of child spacing

Abstinence

Abstinence involves refraining from sexual activity. Abstinence occurs in three different forms: it can be primary, secondary or postpartum. Primary abstinence is when someone has never had sexual intercourse, while secondary abstinence is when an individual has engaged in previous sexual intercourse and decides to abstain. Postpartum abstinence occurs after the delivery of an infant when one or both parents decide not to engage in sexual intercourse (Fagbaminde et al. 2018). Primary abstinence is usually influenced by cultural practices like virginity-testing *kuhlolwa*, which is practised in the KwaZulu-Natal and the Eastern Cape provinces in South Africa (Ndinda, Ndhlovu & Khalema 2017), or

by an individual who just decided not to engage in sexual intercourse for a specific period. This type of abstinence was also practised among AmaZulu, as vaginal penetration was prohibited because they believed that an illegitimate child would disrupt the community (Kies 1987). This is also influenced by the teachings received by adolescents during initiation, where they are discouraged from engaging in sex before marriage. Among African indigenous people, postponing sexual activity until marriage is very important, as this is a symbol of good manners and respect for the self and the elders and their teachings. This is also a practice among the VaTsonga and VhaVenḓa people from the Limpopo province in South Africa. In these societies, the elders (females) would sit close the bridal couple's door during their first sexual intercourse engagement, and if the bride cried during sexual intercourse, the female was regarded as a true virgin (Mothiba et al. 2012). Therefore, it was important for young females to maintain their virginity and, in the process, prevent pregnancy, as young females would not engage in sexual intercourse.

The study conducted in Kwazulu-Natal by Ndinda et al. (2017) identified abstinence as a common practice among the AmaZulu and known as *ukohlolwa* (virginity inspection). According to Ndinda et al. (2017), the Zulu maidens would avoid penetration by engaging in thigh sex, which in isiZulu is known as *ukusoma*. *Ukusoma* is used to prevent pregnancy and is used by both young and older females who have just given birth (Kies 1987; Mothiba et al. 2012; Ndinda et al. 2017). This practice is emphasised by the teachings provided to teenage girls and boys at initiation schools. The elderly males at *tshitamboni* (the secluded portion of a river) teach VhaVenḓa teenage males thigh sex where only males bathe, while the teenage females are taught to avoid vaginal penetration when playing with the young males. However, for the young females, the elderly females would continuously inspect their virginity during different stages of initiation. The AmaZulu also practice virginity-testing, and it becomes a source of pride for families when their daughter is still a true virgin. The intact vaginal hymen symbolises an unbroken calabash, while the broken calabash symbolises the torn hymen. The teachings of indigenous or cultural abstinence among different cultural groups in South Africa, such as the VaTsonga, VhaVenḓa and AmaZulu, are aimed at the prevention of unplanned pregnancy.

A study conducted in Zaire by Bertrand, Bertrand and Malonga (1983) confirms that 80% of the respondents spontaneously mentioned the use of abstinence and withdrawal, which is explained as 'separate beds'. Another study by Rossier and Corker (2017) also confirmed that in sub-Saharan Africa, the indigenous child spacing methods mainly comprised periodic abstinence or withdrawal. It is also documented that these two indigenous methods surpass 5% in other countries, such as Madagascar and Cameroon, Gabon, Democratic Republic of the Congo (DRC) and the Republic of Congo in Central Africa. Additionally, it was indicated that 1 : 5 indigenous child-spacing users in the African region, practices either periodic abstinence or withdrawal. This confirms that these are the most favoured child spacing method on the African continent.

Postpartum abstinence

Postpartum abstinence is a spacing method used for the prevention of pregnancy after delivery, and female elders within the household supervise it. The duration or period of postpartum abstinence is about three months, but this differs according to the practices of various cultural groups. The reason for postpartum abstinence is believed to avoid spoiling or contamination of the breast milk (mother's milk) by male sperm, which consequently affecting the health of the infant. A study conducted in Tanzania revealed that abstaining from sexual intercourse protects infants from a disease called *kubemenda*. The same condition was described in a study conducted in South Africa among the VhaVenḓa, who also revealed that the infant is protected from a disease called *lukala*. An infant affected by *kubememba* or *lukala* presents symptoms, such as recurrent bouts of diarrhoea, malnourishment (more or less similar to marasmus), severe weight loss presenting shapeless baggy buttocks, general body weakness and poor growth (Mbekenga et al. 2013; Mulaudzi 2004).

During the postpartum abstinence period, the mother is separated from her husband and stays with the elder females or the in-laws. These individuals take care of the mother's personal needs, such as assisting he mother in maintaining good personal hygiene and eating healthy food encouraging breast milk production. This is also done to afford the mother more time to focus on the infant and its well-being. The mother sleeps with the elderly females who, in most cases, is the mother-in-law. This ensures that the husband does not go to the residence, such as a hut or the room where the wife is sleeping. Postpartum abstinence is also a means of protecting the mother and child against infection from the husband, who might be having extramarital affairs (Fagbaminde et al. 2018; Kies 1987).

The same practice is observed among the Bapedi, VaTsonga and VhaVenḓa people in the Limpopo province in South Africa. In these societies, the mother must sleep with the grandmother of the infant or elder females until the child is about six-months-old to one-year-old. This practice is done to prevent pregnancy, as the couple might engage in sexual intercourse if they sleep in close proximity, such as in the same room. Therefore, the family has a crucial role to play in child spacing and the prevention of pregnancy.

Breastfeeding is also used as a contraceptive method, as it causes amenorrhea and reduces the chance of pregnancy (Mothiba et al. 2012). The same practice is also observed among the Hamar people of Ethiopia, where postpartum abstinence is used and the period ranges from eight months to one year. Breastfeeding is also used as a child spacing method in Ethiopia, and the period can be from six to nineteen months, depending on the supervising elders (Zerfu et al. 2011).

According to Sutjahjo, Tinning and Smith (2018), among the Papau communities in New Guinea, the practice characterises female fertility with the 'dirt and dangers' of menstrual blood and the blood produced after birth.

These blood products are said to be dirty; hence the mothers are separated from their partners after delivery. There is also the belief that post-delivery blood causes stunted growth among young males and weakens the male's power (Sutjahjo et al. 2018). Postpartum abstinence is practised to prevent infections, spoiling breast milk and child spacing among indigenous African people. The methods are believed to be a good practice whereby the grandparents and elder females in the family have an opportunity to teach young mothers how to take care of themselves and their infants. Additionally, the methods provide support to the mother and infant holistically.

Polygamy as a form of child spacing

Polygamy is used to promote periodic abstinence. About 2.6 million couples still use periodic abstinence in sub-Saharan Africa. Periodic abstinence is another form of natural child spacing, as well as the rhythm method, where couples will not engage in sexual intercourse during a specific period of the female's menstrual cycle. The use of this method depends on the knowledge of the menstrual cycle, and so its implementation is less documented.

Polygamous marriages are encouraged among the Bapedi, VaTsonga and VhaVenḓa. The husband can leave the pregnant mother at this time, at times arranged by the elders, and engage in an extramarital affair until the infant is over one year old (Mothiba et al. 2012). Polygamy is also utilised as a child spacing method among the AmaZulu, as the husband sleeps with another female at least once a month when their partner is not ovulating (Kies 1987). Among the AmaZulu, polygamy used to be a formalised method to abstain from pregnancy as the husband would engage in sessons in another wife's house, while providing a space for their other wife to avoid pregnancy. This practice is also observed in Zimbabwe, where periodic abstinence is an important element of child spacing, which is more pronounced in polygamous families where there is rotational pregnancy (Verkyl 1991).

Additionally, besides being in a polygamous marriage, Zimbabwean females study the moon phases and note the ideal days to engage in sexual intercourse as this signifies the period when they are not ovulating and would not get pregnant, and this practice is called *kudandala* (Jaravaza 2013). This is when a decision will be made to invite the male into one's house to avoid falling pregnant.

Withdrawal methods

The withdrawal method in Zimbabwe is called *ku rasa mbewu*. This method is used to avoid the entrance of male into the female's vagina. On the contrary, the elderly, especially males within the society, consider it taboo because it is like splashing sperm outside (Jaravaza 2013). This is done carefully, whereby the

male ejaculates the sperm cells outside the vagina, and to be able to do this, the male should concentrate during sexual intercourse. This practice reflects that male also play a role in ensuring that the family maintains the set goals of child spacing. The same author indicates that to control the number of children that one should bear, males are made to expose their testicles to average heat (*kudziisa chiuno*). It is believed that the heat weakens the sperm so that it does not fertilise the egg (Jaravaza 2013). All these acts indicate that males take part in child spacing and the prevention of pregnancy. Therefore, health care workers need to involve males in reproductive health care programmes.

The use of plants in the prevention of pregnancy

Different plants or herbs are used to prevent pregnancy; these can be roots, leaves, barks or whole plants (Marole et al. 2019). Among the Bapedi, herbs are mixed and given to females to drink so that they should not fall pregnant. These herbs should be taken orally for a period of three months before engaging in sexual intercourse (Mothiba et al. 2012). Some females from the same cultural group bind their menstrual blood with herbs and traditional medicine, cover it with white cloth and then tie a string around their waist. In some instances, the menstrual blood is mixed with herbs, tied with a white cloth and placed where the females will find it when they want to fall pregnant again. The cloth must be untied and the herbs are thrown away (Mothiba et al. 2012).

The VhaVenḓa also use menstrual blood mixed with herbs as an indigenous practice to prevent pregnancy among young females before marriage, which is known as *u fhahea nowa* (hanging the snake). The mixture is supposed to be hidden on the roof of a hut, and the belief is that if the uterus, commonly known as *nowa* (a snake) is hidden above the floor level, the female will not get pregnant. However, the female is not supposed to be aware of the place where the mixture is hidden. It will only be retrieved when the female gets married so that the female can become pregnant. There is also a belief that if the person who hid the combination dies, the female will lose her ability to conceive.

In Nigeria, females drink herbs as a form of preventing pregnancy (Ajayi, Adeniyi & Akpan 2018). In Malawi, especially in rural communities, the most used indigenous pregnancy-prevention method is a concoction of mixed herbs and water which is taken by females. However, its frequency has not been identified (Koop et al. 2017). The same practice is observed in Ethiopia to control pregnancy where herbs and roots are used; however, these females do not disclose the type of herbs and roots that they use (Zerfu et al. 2011). The Hua females in New Guinea eat small bits of dried brown leaves, which reduce blood flow after childbirth (Sutjahjo et al. 2018).

Table 5.1 shows the different plants used in Zimbabwe to prevent pregnancy. This confirms that traditionally, several methods are used to prevent pregnancy,

TABLE 5.1: Different plants used in the Mutasa district in the Manicaland province, Zimbabwe, as birth control.

Type of traditional birth control	Description
Muchecheni (*Ziziphus* mucronuts)	This herb is believed to cure various ailments. Females collect the bark of the Muchecheni tree (*Ziziphus mucronata*) to boil and drink the liquid every night to prevent pregnancy.
Mukina (*Mucuna pruriens* tree)	The tree roots are ground and soaked in water and consumed orally by females daily for child spacing.
Mbanje (marijuana/cannabis)	The seeds of *mbanje* are taken orally once a year to avoid unwanted pregnancy.
Holy water and oil	The combination of this tincture is consumed orally to avoid unwanted pregnancy.
Madota emaguri (ashes of cobs)	This ashes of maize cobs are mixed with hot water in a sieve and is consumed orally daily and used to prevent pregnancy.

Source: Jaravaza (2018).

either using herbs or other related practices. This calls for clinical health care professionals to know these practices and methods so that they can provide and or treat clients appropriately.

Wearing of artefacts

Wearing of artefacts is also used as an indigenous African birth control method for child spacing. Among the Bapedi, the practice of placing golden safety pins in the mouth of the female during sexual intercourse is often practised. This is done so that the female can concentrate on the pin during intercourse so that they do not release their vaginal secretions that can help the sperm cell to easily move to fertilise the ovum eggs (Mothiba et al. 2012). Meanwhile, in Malawi, the string is also placed around the female's waist to prevent pregnancy (Koop et al. 2017). Another child spacing method used involves burying the placenta upside down and the cord on top within the house. It is believed that this will prevent the female from getting pregnant, and when they want to fall pregnant the female must dig up the place where the placenta was buried and discard the remains (Koop et al. 2017; Maliwichi-Nyirenda & Maliwichi 2017; Marole et al. 2019; Mothiba et al. 2012). However, according to the VhaVenḓa, a foetus after having a miscarriage or delivering a stillborn should be buried in a standing position (vertically) to ensure fertility. It is believed that if it is buried in a lying position (horisontally), the female will never fall pregnant again, because the uterus will be sleeping as well.

On the contrary, in Zimbabwe, wearing a string around the waist is used to facilitate conception, while on the other hand, the placenta is mixed with herbs and buried on an anthill to prevent pregnancy. The placenta is normally retrieved when pregnancy is desired. Another practice observed in Zimbabwe involves jumping over a certain bush from East to West to prevent pregnancy and jumping from West to East to become pregnant (Verkyl 1991). This is the same with plants, herbs and artefacts used; some are also used to prevent pregnancy, while others are used to facilitate a female becoming pregnant.

Religion and birth control

According to the indigenous wholistic theory, individuals are spiritual beings whose decisions are influenced by their spiritual beliefs (Absolon 2019). Every religion has views about fertility and fertility control. There is a belief that the Bible promotes prolific childbirth as indicated in Genesis 1:28, which says to 'be fruitful and multiply', hence most of the time, non-reproductive sexual intercourse is regarded as a sin. In Judaism, the practice of *coitus interruptus* is regarded as evil as the male is said to have spilt the seed on the ground (Christopher 2006). This practice can therefore promote the proliferation of childbirth, which can be detrimental to the health of the mother and child. Among ancient Egyptians, *coitus interruptus* was used as a method of preventing conception, where the female inserted a piece of lemon inside the vagina to act as a barrier to male sperm entering the cervix. This method was the basis for future methods like a diaphragm, conical cap and condoms (Christopher 2006).

In the Islam religion, menstruation is regarded as unsanitary and some restrictions are imposed on a menstruating female, which include not lighting a candle to celebrate religious observations, not touching the Qur'an and fasting during Ramadan. Females within the Islamic religion often use menstruation as an excuse for not engaging in sexual intercourse, and this form of abstinence protects them from being impregnated and consequently provides the required spacing between their children (Christopher 2006).

The Roman Catholic Church prohibits artificial birth control methods, which is a practice rooted in the belief that the end purpose of sexuality is procreation, and hence, interfering with this purpose is a sin (Christopher 2006). Abstinence and natural child spacing are the only birth control methods recommended by the Roman Catholic Church. Natural child spacing involves predictions of when the females will ovulate and, consequently, avoiding sexual intercourse during this period. Ovulation is predicted by measuring the female's basal body temperature and identifying changes in the consistency of the cervical mucus. This method requires the greatest degree of self-control and spousal cooperation. The same religious practices of masturbation among males are said to be a homicide, as the sperm reproductive cells are said not to have been used for its intended purpose (Christopher 2006).

In Hinduism, the common birth control method is withdrawal and *coitus interruptus*. The consent of the wife is always sought and is regarded very important when deciding to have sex to fall pregnant (Christopher 2006). Accordingly, religion also plays a role in matters related to conception, such as procreation and child spacing practices.

Indigenous emergency contraception

Females in pre-colonial sub-Saharan Africa used good-luck charms and indigenous medicines to prevent pregnancy after sexual intercourse

(Agadjanian 1999). Evidently, some South African females drink an ash tincture mixed with hot water after sexual intercourse to prevent falling pregnant (Mothiba et al. 2012). Zimbabwean females ingest herbs from the shrub *Pouzolzia mixta* the following morning to prevent pregnancy (Maroyi 2013; Sewani-Rusike 2013). It is believed that *Pouzolzia mixta*, also known as a soap brush (English), *isikhukhukhu* (Ndebele) or *munanzva* (Shona). has post-coital contraceptive properties. According to Bhathena and Guillebaud (2011), plants with post-coital contraceptive properties can prevent unwanted pregnancies.

Infertility

Infertility is a health and social problem that affects both males and females globally, and Africa is no exception. Infertility is closely related to procreation. In African cultures, infertility is considered a punishment from the ancestors and the blame is always placed on the female; hence, infertility diagnosis and treatment also need to be understood from the African perspective. Treatment modalities can be based on either Western medicine or African traditional medicine. It should be noted that in Africa, the use of indigenous medicine to treat infertility has been a practice since ancient times and is still in practice to date. This section, therefore, discusses infertility, its diagnoses and traditional treatment modalities for females and males. Infertility is also a painful thing to experience. The pain threshold in females is much greater as compared to males because society expects every male infant's according to African culture.

Male infertility

Male infertility is described as the failure of a male to impregnate a female after regular unprotected sexual intercourse for about a year (Emokpae et al. 2007). The subject of male infertility is not widely discussed, especially among indigenous people of Africa. Females usually bear the brunt of being infertile and are always blamed for childlessness (Dyer et al. 2004; Madziba 2009).

Indigenous ways of assessing infertility among young males

There are different indigenous ways of assessing infertility among males, which are practised in different parts of Africa. Among the Shona-speaking people of Zimbabwe, the grandmother and mother of the infant would regularly check the growth and size of the male infant's testicles and penis. The report of this assessment is given to the uncles. This process helps to identify any irregularities in the male infant's reproductive organs which would require urgent remedy (Moyo 2013). In the same culture, the mother also observes the male infant's penile erection in the morning, when urinating, when asleep or when removing a napkin (a napkin or 'nappy' is a piece of towelling held between the legs of an infant and pinned at the sides with safety pins to soak up any bodily excretions.).

These observations are conducted over a period of six months and the observance of a penile erection is said to be a sign of fertility.

At puberty, young males also undergo tests to identify infertility. The tests are done during masturbation, where potency, ejaculation, sperm-cell quality and quantity are examined. This examination is done under the watchful eye of their grandfathers and uncles. During these examinations, young boys are made to ejaculate on the palm of their hands or on a calico cloth. It is expected that the sperm fluid should stick to the palm or cloth. The failure of the sperm sticking to the cloth is a sign that the sperm-cell quality (Moyo 2013).

Young males are also made to submerge into warm water in a river during the afternoon and are instructed to move deeper into the body water until the water covers the penis level. At this level, they are told to relax and stand still, and should the penis float on top of the water, it is concluded that the young males are infertile (Moyo 2013). Another strategy used involves taking the young males to the riverbank. At the riverbank, stones are arranged in a line of about 2 cm. Young males are then asked to masturbate with the hope that, with an erection, the stones will be pushed into the river and failure to push stones into the river is regarded as a sign of infertility (Moyo 2013).

Urine tests are also conducted when young males are taken to a forest at around eight o'clock in the morning. In the forest, a demarcation line is drawn at 2 cm, where young males are expected to urinate past the demarcation line. Failure to urinate past the demarcation line is a sign of infertility (Moyo 2013).

Different concoctions and tinctures are also made to diagnose infertility. Young males are instructed to eat raw eggs, milk, a powdered concoction from plant or tree roots and tree barks. These solutions are given to young males to drink and they are expected to not vomit, as vomiting is considered a sign of infertility (Moyo 2013). Upon marriage, the bride is asked to place the husband's ejaculation on a calico cloth. If the calico cloth appears starchy in the morning, it would signify that the sperm is fertile. These practices are believed to assist in establishing the fertility status of young males. Surprisingly, when these young males are adults they are not examined for infertility, and it is the females who carry the burden of infertility.

Treatment of male infertility

Among the Shona-speaking people, two of the following strategies are used in the treatment of infertility. A traditional medicine called *makondwa* or *maguechue* is given to all young males at puberty. This concoction is prepared from tree barks and roots, water and *mahewu* (porridge). Young males are told that the medicine will strengthen them and thicken their sperm. After these treatments, the young males are retested, and if the problem persists, the treatment is repeated.

The second treatment is used after the second test, where the help of the traditional healer is sought. The traditional healer uses traditional bones, spirits, mirrors, horns and knives to unearth the underlying problem. While resolving the encountered problem, a concoction in the form of inhalations, infusions, fumigations and scarification is given to the affected young male. In cases where the cause is associated with unhappy ancestors, the family is asked to brew beer and ask for forgiveness from their ancestors (Moyo 2013). However, when they are adults, they will not go to seek help for infertility and only females are subjected to such infertility treatments. Therefore, these practices need to be known so that health care professionals can provide relevant counselling to these couples.

Infertility in females

Infertility in females is defined as the inability to conceive after one year of regular sexual intercourse. This poses a major problem in Africa, as it is usually associated with witchcraft or angry ancestors, and females are mostly blamed for infertility. The females suffer severe negative social consequences, such as stigmatisation, ostracism, abuse and economic deprivation. Hence, its effective management impacts their reproductive health (Dyer et al. 2002). This confirms that infertility in females is some form of punishment which is not a fair judgement. Therefore, females need to be empowered on these issues so that they could be able to seek proper care. It is, therefore, crucial for health care professionals to be aware of these practices so that culturally-sensitive care can be provided.

Causes of infertility in females: A traditional perspective

Causes of infertility among African females are attributed to different things ranging from witchcraft, angry ancestors and punishment from God. In a study conducted among the AmaXhosa females from the Western Cape province in South Africa, it was noted that there was a belief that infertile females are bewitched by jealous females, who could be their husband's previous girlfriends or mother-in-law (Dyer et al. 2002).

Females in Gambia describe infertility as *the womb being jealous*, and this can be corrected by someone close to the female getting pregnant, as this will increase the likelihood of the womb of the infertile female also conceiving (Dierickx et al. 2019b). Several myths exist related to the causes of infertility, which may result in females not seeking the appropriate help. Health education related to the real causes of infertility is required so that females can seek help from relevant individuals who might assist in treating infertility. Health care professionals should also know the existing myths related to the causes of infertility, so that they can be able to provide necessary help and health education.

Indigenous ways of treating infertility among females

The indigenous treatment of infertility usually involves orally consuming herbs or medicine to be 'cleaned'. These herbs are normally found in the immediate surrounding. *Juttoo* is a remedy made of roots that clean the stomach to restore the womb after suffering a miscarriage, and is widely used among Gambian people (Dierickx et al. 2019a). In contrast, among Maasai people, when females do not conceive, they are advised to go away and have sex with other males to impregnate them, and when the mother gives birth, the offspring are taken as that of the husband (WHO 2010). However, this practice should be discouraged as it can be the source of spreading sexually transmitted infections (STIs).

Recommendations

It is recommended that the indigenous practices and methods of child spacing should be included in the training curriculum of health care professionals, such as nurses and medical doctors, so that they can be able to understand and treat patients holistically. Further research is needed to test the efficacy and safety of some indigenous medications. African governments should support and promote integrated health care systems that recognise the indigenous child spacing methods because they promote the health quality of the mother and child. Reproductive health should be a collaborative effort between the Western and indigenous health care systems to promote the health of mother and child. Communities and traditional leaders should be actively involved in reproductive health care because they are the custodians of indigenous health care systems.

Conclusion

The chapter outlined various aspects related to indigenous and or cultural methods of child spacing and prevention of pregnancy and how they are viewed in different communities. Additionally, various methods of sexual intercourse abstinence were outlined. These child spacing and methods of preventing pregnancy are valued at all levels in the community starting from the family to the societal level. The causes of infertility were outlined and the related views at a societal level were discussed. The indigenous wholistic theory was used to embed related issues of child spacing, infertility and the causes thereof. Therefore, it is of paramount importance that health care providers consider every females seeking child spacing and prevention of pregnancy services, as a whole interconnected physical, spiritual, mental, and emotional elements. Health care professionals must, therefore, promote and understand the co-existence of indigenous and Western knowledge and approaches to child spacing and prevention of pregnancy. In addition, Africans

exist in a sphere whose psychological, economic, social and political factors affect them differently. Many are, however, marginalised, but they still practice their indigenous methods of child spacing and pregnancy-prevention. To summarise, health care professionals should provide females with holistic care that respects their cultural practices without discrimination or stigmatisation.

Glossary

- ***kubememba/lukala*:** A disease that affects breastfeeding babies, caused by contaminated mother's breast milk if parents engage in sexual intercourse. It is believed that the breast milk would be contaminated by sperm and the baby will suffer from *lukala* (in Tshivenḓa) or *kubememba* (according to Zimbabwean culture). The symptoms resemble that of marasmus or malnutrition.
- ***makondwa/maguechue*:** An indigenous mixture prepared from tree barks and, water and *mahewu* [porridge] which is given to young males at puberty to thicken their semen and improve fertility.
- ***u fhahea nowa*:** In Tshivenḓa, literally it means to hang a snake (a uterus in Tshivenḓa is referred to as *nowa* [snake]). An indigenous practice by the VhaVenḓa of mixing the menstrual blood with some herbs and hiding it on the roof of a hut or place of residence to prevent pregnancy.

Chapter 6

African indigenous beliefs and practices during pregnancy, birth and after birth

Maurine R. Musie
Department of Nursing Sciences,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Rafiat A. Anokwuru
Department of Nursing Sciences,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Roinah N. Ngunyulu
Department of Nursing,
Faculty of Health Sciences, University of Johannesburg,
Doornfontein, South Africa

Sanele Lukhele
Department of Nursing,
Faculty of Health Sciences, University of Johannesburg,
Doornfontein, South Africa

Abstract

Midwifery care has existed since time immemorial. Among indigenous Africans, giving birth was a normal process where females used to deliver at home under the care of birth mothers. However, this communal practice was displaced during colonisation and was replaced by midwifery that was conducted in hospitals under controlled environments and bureaucracy of the health care systems.

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Indigenous midwifery care (*mahlayiselo ya vasungukati*) believes that the birthing process extends from before and during pregnancy to during and after the delivery. Successful outcomes of pregnancies depend on compliance with the practices and beliefs associated with the birthing process. To date, pregnant females still engage in indigenous practices and beliefs during pregnancy, labour and post-delivery. However, these practices sometimes clash with modern practices of midwifery.

This chapter reviews the African indigenous beliefs and practices during pregnancy, labour and post-delivery. These include practices such as indigenous measurement and monitoring of pregnancy till the expected day of delivery, delay of early labour and treatment of minor disorders of pregnancy. Religious beliefs during the prenatal period, labour and post-delivery, maternal nutrition and taboos to be avoided are discussed. Each section includes the implications for the health care practitioners.

Understanding the indigenous antenatal practices by health care practitioners will improve and contextualise cultural care towards pregnant females in clinics and hospitals; it will also assist in the return of indigenous practices.

Indigenous midwifery care

Many countries have started promoting the use of traditional and indigenous midwives. Countries like Canada have seen a resurgence of indigenous midwives, skilled and knowledgeable females who assist young females during pregnancy, birth and postpartum. The rise is because of indigenous midwives' understanding and respecting clients' cultures, languages, beliefs, practices and traditions (Couchie & Sanderson 2007). However, in other countries, indigenous midwives are looked down upon and the word 'traditional birth attendants' has been coined to categorise them as inferior and undermine their practice. This is evident mainly in some of the African countries where they practice. The ignorance and marginalisation of cultural traditions in indigenous midwifery have brought a lot of challenges regarding maternal and newborn outcomes. The gap has been identified by the World Health Organization (WHO) (1992; Sibley, Sipe & Barry 2012). There is a realisation of the importance of acknowledging the role played by indigenous midwives in curbing maternal mortality rates globally. Policies have since been promulgated for countries to incorporate indigenous midwifery and traditional birth attendants as part of the primary health care team (Stoyles 2015):

> Persons are not abstract entities but rather personified human beings in the world and that personhood depends on developing a history with other persons within families and communities with distinctive values and traditions. (p. 92)

In the above statement, Stoyles (2015) emphasises the value of pregnancy and the meaning of pregnancy loss captured in an African context.

Physiologically a female is designated the role of carrying the pregnancy, but culturally, when a female is pregnant it involves the female, the husband, the external family and the community (Arghavanian et al. 2019; Ngomane & Mulaudzi 2012). The cultural beliefs and practices have designated roles for the husband, the external family in the form of the grandmother or mother-in-law and the community towards the successful outcome of the pregnancy. Thus, in understanding antenatal care from an African perspective, it is crucial to understand the indigenous practices relating to pregnancy, the female, the husband, the family and the community.

Indigenous practices *of maendlelo ya ndzhavuko/ulwazi ngezemvelo nezendabuko* (Idang 2015) impact decisions and activities of everyday living. It is therefore an important factor in the care of a pregnant female. Indigenous practices are expressed in the attitude and behaviour of a female as prescribed by her community (Zepro 2015). Understanding the dos and don'ts and the societal norms and expectations around pregnancy provide the midwife with tools that enhance the provision of culturally relevant care to the mother and unborn child (Swihart & Martin 2020).

Culturally, the beliefs and practices around a pregnant female are presumably geared towards a safe delivery. Many of the indigenous practices in Africa are linked to cultural and religious beliefs and values (Ndemanu 2018). Cultural beliefs shape people's thinking, worldviews and, consequently, their practices (American Nurses Association 2020; Idang 2015; Ndemanu 2018). The colonisation of Africa by the Western world led to the forceful relegation of the culture as irrelevant and unimportant (Ntuli 2018). Colonisation changed the primary beliefs of African people to secondary beliefs and promoted Western practices as primary and better.

African scholars seek to promote and restore indigenous practices and beliefs. Given this, this chapter reviews African indigenous beliefs and practices during pregnancy. The beliefs and practices highlighted in the chapter are representative of various regions of the continent and include Southern Africa, Western Africa and Eastern Africa. Some of the practices are aligned with the expectations of modern midwifery practices, such as fundal height measurement and monitoring of pregnancy till the expected day of delivery, delay of early labour and treatment of minor disorders. Also covered in the chapter are religious beliefs during the prenatal period, maternal nutrition and taboos to be avoided when pregnant.

Understanding the value of pregnancy in Africa

In Africa, pregnancy [*ukukhulelwa/nyimba*] is highly valued because children are seen as wealth, lineage progenitors and a retirement investment (Chimbatata & Malimba 2016; Naab, Lawali & Donkor 2019). They are a gift

from the *amakhosikazi akithi* (the grandmothers and elderly females, who have passed menopause) (Brindley 1985). The understanding of pregnancy in Africa goes beyond the general understanding. It is understood as the period when a female misses her normal monthly menstrual cycle, and a baby starts to develop in the uterus of the female for nine months (Dyer 2007). It is viewed as sacred and should happen within the context of a marriage (Palamuleni, Kalule-Sabiti & Makiwane 2007). It is that period when a female's status is about to change forever, as she would thereafter be known as a mother. Baloyi and Manala (2013) aver that a mother is regarded as a precious ornament, and a pregnant female will therefore guard her pregnancy by observing all the traditional practices to attain the status of motherhood. The high value placed on children and childbearing is expressed in the Yoruba culture through the different proverbs that show the value of children and how they should be cared for. Yoruba proverbs centred on children include *omo laso* (children are covering) *and omo niyi* (children are the prestige) (Omobowale, Omobowale & Falase 2019).

It is therefore a great joy for a female when she is pregnant within the first year of marriage and would do everything within her control to bear and keep the prestige of motherhood. The value of children in Africa and the link to the curse from the evil spirit or witches that are presumed to be the cause for their inability to have children may explain the subsequent need to protect pregnant females. The belief in the existence of witches and evil spirits that seek to harm the unborn baby leads to families seeking help from their ancestors for the protection of the unborn baby. This belief is one of the reasons why a pregnant female is expected to hide the pregnancy or keep the pregnancy a secret till it is visible or the signs of pregnancy are established. Though the female is expected to keep the pregnancy a secret from everyone, the pregnancy is made known to the mother-in-law or the granny of the house (Brindley 1985; Ngomane & Mulaudzi 2012).

Most of the traditional practices are therefore channelled to appease the ancestors to seek protection from evil spirits and witchcraft and ensure the safe delivery of the baby. Mothers-to-be engage in these traditional practices to ensure their safety and that of the unborn baby (Aziato, Odai & Omenyo 2016).

Practices and beliefs to protect the mother and the unborn baby differ from community to community. These include wearing protective amulets, use of herbs and observance of the stipulated rites in pregnancy (Aziato et al. 2016; Mogawane, Mothiba & Malema 2015).

Implications to health care practitioners

Studies have shown that African females present late for antenatal care services in modern medicine. Understanding the concepts and values of

pregnancy in Africa will help the midwife to recognise the reasons behind the late presentation and some behaviours of African females during pregnancy. It will also help the midwife to understand the importance of having a child and its link to the behaviours of pregnant females at the antenatal clinic or antenatal services. Thereby, the midwife will be able to treat every pregnant female as precious and subsequently administer the appropriate antenatal care measures.

Pregnancy age calculation and sex determination

Traditional diagnosis of pregnancy relies on the symptoms and signs seen in the pregnant monther (Oyebola 1980). One of the ways of confirming a pregnancy is when a female misses their menstrual cycle. Once the pregnancy is confirmed, the female reports to the mother-in-law or the grandmother of the house (Ngomane et al. 2012). In addition to missing the menstrual cycle, the elderly female notices changes in the female's appearance and behaviour. For some females, pregnancy is confirmed by morning sickness, which is characterised by nausea and vomiting accompanied by a change in eating patterns and the missing of the period, which eventually confirms that the female is pregnant. Another way of confirming pregnancy is the palpation of foetal parts by the traditional birth attendants (Selepe & Thomas 2000). In ancient Africa, females were taught to participate in the measurement of the gestational age and monitor the growth of the pregnancy. The females were taught to mark the tree at the rise of each new moon and, at the ninth marking, prepare themselves for delivery. In addition, the birth attendants calculate the pregnancy with the moon, and it is expected that after the ninth moon, which is the ninth calendar month, the pregnant female is expected to deliver within the next four weeks (Larsen, Msane & Monkhe 1983). The birth attendants also monitor the foetal heartbeat with the use of a horn that resembles the modern fetoscope. Among Vatsonga, the female is given a grass known as *ritlangi* by the traditional health care practitioner to tie around her waist. As the foetus grows bigger, the grass is expected to become tighter around the waist of the female. This practice allows for participatory medicinal practice as the female grows to be conscious of herself and her weight. She can understand if the foetus is growing or not and it is a basic scientific way of diagnosing intrauterine growth retardation or any other maldevelopments of the foetus (Ngomane & Mulaudzi 2012; Selepe et al. 2000).

Many of the cultural beliefs on prediction centre around the throwing of bones and communication with ancestors. Determination of the sex of the baby also depends on the throwing of bones and the physical presentation and expression of the expectant mother's appearance throughout the pregnancy (Steingo 2019).

The use of herbs and indigenous medicines in pregnancy

Adherence to indigenous practices during pregnancy is central to the well-being of the unborn baby and the mother. One such practice is the use of herbs and indigenous medicines to maintain the pregnancy and prepare the female for safe delivery. These herbs are sometimes prepared on their own or with some other ingredients. They are administered to the pregnant in the form of mixtures, drinks, powder or food. The preparation of these herbs and indigenous medicines differs from community to community and region to region; however, most of the ingredients are similar. Some of the ingredients used are herbs from plants, products from animals, fish, clay, soil and metals (Illamola et al. 2020).

There are varied reasons for the use of indigenous medicine and herbs during pregnancy. The prevalent use of herbs among pregnant females is based on the indigenous background of the people. It makes the females feel connected to their cultural roots. In addition, the use of herbs and indigenous medicines is believed to wade off evil and protect the unborn baby from witchcraft. Pregnant females also make use of indigenous medicines and herbs, assuming that they are cheaper, easily accessible and pose no side effects (Duru et al. 2016).

There are common herbs used during different trimesters in pregnancy across the regions. The herbs discussed here are not exhaustive but rather common herbs. Many of the indigenous herbs and medicines are taken during pregnancy are targeted toward the first and third trimesters (Nergard et al. 2015).

The first trimester of pregnancy is usually a turbulent period for pregnant females. They are faced with minor disorders such as nausea, vomiting, backache, pica, heartburn, indigestion and many more. During these discomforts, many females resort to herbal treatment. These herbs are easy to find and affordable (Duru et al. 2016). According to Bayisa, Tatiparthi and Mulisa (2014), the sustained use of these herbs in Africa is because of the believed potency against these illnesses. The commonly used herbs include garlic, ginger, bitter leaf, palm kernel, cinnamon, jute leaves, aloe vera, lemon, and bitter kola (Mothupi 2014).

Bitter leaf is one of such common herbs used in West Africa in countries such as Nigeria, Malawi, Ghana and Sierra Leone; East African counties such as Uganda, Ethiopia and Tanzania (Oyeyemi et al. 2018). The herb is known for the protection provided against malaria and the help in fighting anaemia. The herb is boiled and taken as a tea and sometimes used as food (El Hajj & Holst 2020). Pregnant females in South Africa and West Africa consume sour plums/wild plums (*Ximenia caffra*) to improve appetite and combat nausea and vomiting.

The fruits can be eaten whole, while the leaves are boiled and taken as a drink or inhaled (Nergard et al. 2015).

The third trimester involves the last three months of pregnancy. Traditionally, pregnant females prepare for the delivery of the baby. One of the popular preparations is the use of herbal medicine to induce delivery. The most popular and vastly researched herbal medicine used during pregnancy in South Africa among AmaZulu is *isihlambezo* (herbal decoction). Few studies have documented the use of traditional medicines during pregnancy and labour in South Africa (Hlatshwayo 2017; Illamola et al. 2020). The South African social anthropologist and pharmacologist Varga and Veale (1997, p. 911) define *isihlambezo* as a herbal decoction that is commonly utilised by many Zulu-speaking females as a preventive health tonic during pregnancy, which is also presumed to work in providing anaesthesia and analgesia during delivery. It is believed it will help a female have a smooth, painless delivery. Naidu (2013) define*s isihlambezo* as that which cleans. The term *isihlambezo* originated from the isiZulu verb *ukuhlamba,* which means to cleanse ceremonially for protection against evil spirits.

The traditional remedy *isihlambezo* is a decoction made from extracting salts and minerals of plants from areas such as roots, bark and wood. The extracts are then boiled and steeped for several hours, which the females will ingest the *isihlambezo* in the form of a tea (Naidu 2013). This decoction is taken specifically during the third trimester as an antenatal tonic medication with the belief that it promotes a favourable course of pregnancy and facilitates precipitated and uncomplicated labour (Naidu 2013). Many different plants can be used as i*sihlambezo* ingredients, and the recipes vary depending on factors such as the traditional healer consulted, the condition of the female, the geographical area or residing community. The most cited composition of the decoction includes *Clivia miniate*, *Agapanthus africanus*, *Pentanisia prunelloides* and *Gunnera perpensa* (Illamola et al. 2020).

Implications to health care practitioners

An understanding of the different types of herbal medicine used during the first, second and third trimesters of pregnancy will equip the health care practitioner with information that will aid in the right diagnosis and management of a pregnant African female.

Culture and expected behaviours during the antenatal period

Prenatal beliefs

The prenatal period is the period of foetus development from conception to birth and any alteration affects the outcome (Dean & Grizzle 2011).

Africans believe the prenatal period is essential and sensitive and is the time when a pregnant female should receive all the love and care. There are diverse beliefs and practices held about this period that have been followed from generation to generation. One such belief and practice is sex during pregnancy. Beliefs relating to the expected sexual behaviour vary across culture in terms of duration, frequency and abstinence.

While some believe that sex should be avoided during pregnancy, others believe that sex can happen during pregnancy but depending on the trimester of the pregnancy. Avoidance of sex during pregnancy is associated with different reasons. According to Baloyi et al. (2013), in Botswana, one of the reasons for abstinence is related to the impurity associated with pregnancy. Baloyi et al. (2013) state that a pregnant female is impure from the time of conception till the baby is weaned and, therefore, should not engage in sex. They also stated that as bringing the baby to life is a sacred process, the female must not contaminate the baby's innocence. Secondly, in some communities in Africa, it is assumed that engaging in sexual intercourse during pregnancy can lead to miscarriages and deformities of the baby. For instance, in the Ewe culture in Togo, males are not permitted to have sex with their wives to prevent miscarriage of the pregnancy (Kiemtorè et al. 2016). In the southwestern part of Uganda, not only are males not permitted to have sex with their wives, but they must also abstain from any form of infidelity till the wife has delivered. It is believed that engaging sexually with other females will bring misfortune to the mother and baby (Beinempaka et al. 2015). The Kalenjin in Kenya believe that a pregnant female must abstain from sex because the semen of the male harms the foetus and may result in the death of the baby (Riang'A, Nangulu & Broerse 2018). Similarly, in the Bohlabelo district of Limpopo, females are prohibited from having sex for the entire duration of the pregnancy to protect the unborn baby. Pregnant females are expected to sleep with their mother-in-law (Ngomane & Mulaudzi 2012).

In Madagascar, sexual activities are allowed in the first three months of conception and the last month of conception. Sex is not allowed in the second and last trimesters. It is believed that sexual activities during this period affect the formation of the baby and the baby may be born with a deformity (Morris et al. 2014).

Similarly, in Zimbabwe, the husband is expected to have frequent sex with the pregnant female during the first three months of the pregnancy to enhance the formation of the baby. This is also practised in the Zulu culture (Brindley 1985; Mutambirwa 1985).

Aside from abstinence during pregnancy, the state of mind of a pregnant female affecting the wellness of the unborn child is another prenatal belief that is equally important. Africans believe that the mood of the mother affects the unborn baby. Mutambirwa (1985) adds that the husband should shower

his expecting wife with gifts to preserve a healthy and happy state of mind. The belief is that a happy female is a healthy female and happiness affects the attitude of the baby when born. Furthermore, during the prenatal stage, a pregnant female is encouraged to engage in minimal exercise to prevent abortion or malformation of the baby (Larsen et al. 1983). To prevent this, the female is given herbal concoctions to prepare and strengthen the uterus throughout the pregnancy.

These beliefs differ in contextual meaning from region to region. M'Soka, Mabuza and Pretorius (2015) affirm some social behaviours that are deemed acceptable during pregnancy. Faithfulness to one's partner is considered an expected behaviour during pregnancy. It is believed that a pregnant female must be loyal to her partner to avoid obstructed labour and convulsion during delivery (Maimbolwa et al. 2003).

Food beliefs

Cultural expectations from expecting mothers extend to the foods that can and cannot be eaten. Forbidden foods come in the form of food taboos in the communities. Food taboos are common globally for both females and children. Food taboos are restrictions on eating certain foods, and these are based on religious and cultural or ancestral beliefs (Getnet, Aycheh & Tessema 2018). The reinforcement of the food practices and beliefs is done by the elders in the family and community. According to Chakona and Shackleton (2019), pregnant females are forbidden from taking food that is of the most benefit to them and the unborn baby.

In addition, a group of nutritionists has reiterated the importance of a female planning to be pregnant consuming a healthy diet before conception. This is very important because pre-conception nutrition provides the initial nutrients that a foetus needs (Stephenson et al. 2018). Nevertheless, maternal nutrition at conception and pregnancy periods are equally or even more important because it affects the development of the baby, the state of health of the mother and the positive outcome of the pregnancy (Ugwa 2016). In medical terms, maternal nutrition should be rich in iron, protein and vitamins. Although these food beliefs sometimes differ from the standard prescribed in Western medicine for expecting mothers, the principle of ensuring that the mother and the unborn baby get the adequate needed amount of food remains the same (Hlatshwayo 2017).

The indigenous practices and beliefs on maternal foods in Africa can be both valuable and detrimental to a female and the unborn baby (Chakona & Shackleton 2019). Some of these beliefs also prescribe the amount and type of food to be taken that will lead to safe delivery (Ekwochi et al. 2016). African pregnant females adhere to their food beliefs and practices primarily as a form of respect and allegiance to their ancestors and for the safety of their

babies (De Diego-Cordero et al. 2020). Some of these beliefs are good, while others are injurious to the pregnant females and the development of the foetus.

The indigenous beliefs and practices are similar across Africa, with only slight differences in the types of food depending on the accessibility and knowledge (Ekwochi et al. 2016; Ugwa 2016). For instance, in Zambia, pregnant females are forbidden from eating okra whereas, in Nigeria, pregnant females are to abstain from eating snails to avoid giving birth to a sluggish baby (Ekwochi et al. 2016). Common beliefs and practices include avoiding certain types of foods that can cause the foetus to grow too big, leading to prolonged and difficult labour; avoiding foods that can have a negative impact on the behaviour of the baby when born (Chakona et al. 2019; M'Soka et al. 2015; Ugwa 2016). For instance, there is the belief that pregnant females should avoid fatty food because it causes thick or excess vernix, which causes a delay in pregnancy. They are to eat indigenous plants and leafy vegetables. These enhance blood formation and when there is adequate blood in the female, she has the strength to push during delivery and contribute to a successful outcome of the pregnancy.

Food beliefs in southern Africa

Food beliefs are similar in southern Africa. A study conducted by Chakona et al. (2019) in the Eastern Cape province of South Africa showed that females are forbidden from eating naartjies for fear of giving birth to a jaundiced baby. In the same study, females reported that they were told by elders not to eat fish, otherwise their babies would be born with skins that look like the scales of fish. Leftover foods must not be eaten for fear of having difficult labour and the baby suffering from difficulty in breathing. As established in the paragraph on the preciousness of a child, pregnant females practice these beliefs to secure the safety of their unborn babies. Similarly, a study conducted by Zinyemba (2020) among the Vatsonga revealed similar patterns; pregnant females were forbidden from eating food that was hunted and seafood and even potatoes. Among the Vatsonga, pregnant females are not allowed to eat eggs, while VhaVenḓa do not allow pregnant females to eat spicy foods as they believe the baby will be born with red eyes and sugarcane is also not allowed because the glucose will affect the skin of the baby.

Food beliefs in eastern Africa

In Kenya, the Kalenjin believe that an expecting mother should abstain from eating eggs, animal organs such as the heart, tongue and, sometimes, whole sections of animal meat. It is considered that when an expecting mother eats eggs the baby will grow up learning to steal and eat animal organs, and it is seen as a disrespect to males. In addition, to avoid large infants and potential caesarean

sections, expecting mothers are to sparingly eat protein-rich food and high-energy-giving foods such as *ugali*, a mixture of corn flour, millet and sorghum.

The food beliefs among the Maasai are slightly different from the Knjin. The Maasais are traditionally known for their pastoral living, and this influences the type of food they consume. They eat meat only during special occasions in which a major part of the food goes to the fathers or males in the community (Oiye et al. 2009). They do not believe in farming the land for crops and this affects the amount of food available. In addition to these beliefs, most vegetables are left for livestock. These beliefs limit the value and amount of nutrition in the food available to pregnant females.

The food taboos in Uganda are mainly targeted at child-bearing females and children. Even though it is similar to those from Kenya, in Uganda, females are not allowed to eat animal products such as the back of the chicken or goats. It is considered disrespectful to the male and the female might die if she eats these (Riang'a, Broerse & Nangulu 2017). Pregnancy does not change the status quo; in reality, there are more food restrictions for a pregnant female with the associated belief of keeping her and the baby safe. These food restrictions involve avoiding milk intake during the rainy season to prevent babies from crawling or walking like a caterpillar. In addition, to prevent miscarriage, placenta retention or even death, pregnant females are not permitted to eat offal and ribs of goats and cattle (Riang'a et al. 2017).

Food beliefs in western Africa

Food beliefs also vary in western Africa. In Nigeria, expecting mothers are not allowed to eat snails, eggs, grass cutter milk, okra and fatty foods. It is believed that if expecting mothers ingest these prohibited foods when pregnant, the newborns will have excessive salivation.

In Ghana, the food beliefs are similar to that in Nigeria but differ based on the regions in Ghana. The northern part of Ghana prefers to have fermented food, while the southern part of Ghana prefers non-fermented foods. The ingestion of these foods is based on perception rather than facts (De-Graft Aikins 2014). For more food and nutrition relating to edible vegetables, refer to Chapter 13.

Implications for health care practitioners

Understanding the health care education needs of an expecting mother is important for successful delivery. As established earlier, the expecting mother cannot be divulged from her beliefs and practices. The diet control of an expecting mother gets under way ahead of pre-conception, and it is often influenced by the cultural norms and practices of the community. It is therefore of utmost importance for midwives to understand the beliefs and practices around the diet of an expecting mother to ensure that appropriate advice is given.

Indigenous practices during labour

Indigenous knowledge systems and practices in South Africa seek to acknowledge the contribution of traditional medicine in attempts to go beyond the biological aspect of the human body and also recognise the spiritual aspects (Mogawane et al. 2015). The authors recognise that very little attention is paid to indigenous cosmogeny with respect to the traditional practices related to pregnancy and childbirth. Indigenous practices during childbirth may include plants, animals, spiritual modalities and other techniques unique to the various cultures. Within the South African context, AmaZulu calls childbirth *ukubeletha*.

The WHO estimates that 60% of the population in developing countries utilises traditional medicines. Furthermore, 69.9% of expecting mothers prefer traditional medicine during childbirth because of its safeness, availability and efficacy (Mawoza, Nhachi & Magwali 2019).

The implication on health care practitioners

During history-taking, the midwives need to identify females who use the pluralistic health care systems during pregnancy and childbirth. The identification will assist with the effective management of the female during her pregnancy and labour processes.

Preparation of *ukubeletha* (labour)

The WHO (2015) defines a traditional birth attendant as 'an individual that assists the pregnant females during childbirth, and who initially acquired the skill of delivery by conducting births herself or through apprenticeship'. The traditional birth attendant/traditional midwives are responsible for the preparation of the female during the entire birthing process (Nwadiokwu et al. 2016). Firstly, the traditional birth attendant needs to clean the hut, which will be used for labour. Furthermore, make sure that there are clean clothes for the delivery process and clean, fresh water. In Zimbabwe, a fire is made to keep the delivery hut warm (Lefeber 1994; Makoae 2000).

As part of preparing for the labour process, the traditional birth attendant needs to be familiar with the expecting mother's beliefs and customs concerning childbirth. The birth rituals practised for the actual childbirth process vary across ethnicities and cultures. Locations for homebirths are also different. Some births take place in the house of the expectant mother, the expecting mother's maternal home or the traditional birth attendant's hut (Nwadiokwu et al. 2016; Ohaja & Anyim 2021). In Udhuk, Ethiopia, the birth takes place on a stone to symbolise the mother's hard work. However, in the Western parts of Ethiopia, females are expected to give birth in the bush on

their own. They believe that others are not to see the blood of a female during childbirth because it is cursed. She can return home only when she is cleansed after delivery (Nwadiokwu et al. 2016).

Another perspective is that males and any other person in a state of impurity, such as menstruation, are forbidden to be present in the house where delivery is taking place. The reason for the practice is that the foetus will feel ashamed to be born, thus causing obstructed labour (Nwadiokwu et al. 2016; Treacy, Bolkan & Sagbakken 2018).

Implications and considerations for health care practitioners

It is imperative for health care professionals to be knowledgeable of the cultural beliefs associated with the preparations of labour to be able to provide culturally appropriate care for females. Respecting and incorporating the female's cultural beliefs should be adopted by the health care facilities. Skilled birth attendants are moving towards allowing birth companionship during labour; thus, a female should be given a choice.

Herbal medicine to prepare for labour

The Vatsonga of South Africa use herbal medicine called *xirhakarhani* to ease labour and prepare for labour. The traditional birth attendant would prepare the *xirhakarhani* an indigenous analgesic, by boiling the plant and then giving it to the childbearing female to drink during labour (Ngomane & Mulaudzi 2012). Similarly, this is done by the Ndau people of Zimbabwe. They use the traditional medicine called *demanhandwe* for *masuwo* (childbirth). The *demamhandwe* is a plant that grows throughout the year but mainly during rainy seasons. The roots are bulbs resembling potatoes. It is then boiled and given to a birthing female. The main use of the herbal mixture is to widen the birth canal, promoting cervical ripening and dilatation during *masuwo* (Hlatshwayo 2017). Basotho in South Africa crush ostrich eggshells and administer them to expecting mothers to ease the childbirth process (Van der Kooi & Thepbald 2006).

Implications and considerations for health care practitioners

The knowledge of preparation and practices needed before a birth is important to health care practitioners as this might explain the reasons behind some obstructed labour that defies scientific explanation. Thus, helping health care practitioners prevent further complications during labour and prevention of maternal and neonatal mortality is crucial.

Progress of labour (*isigaba sokuqala sokubeletha*)

Before the onset of uterine contraction, the following beliefs are known to hinder the delivery process. It is crucial to prevent bad spirits from affecting the mother as this is associated with poor progress of labour and is discussed further.

Protection and prevention from being affected by evil or bad spirits (*ukuvimbela imimoya emibi*)

There is a strongly held belief that a pregnant female should not make it known to her neighbours or relatives that her labour has begun for fear of attracting evil spirits that might cause complications during labour (Maimbolwa et al. 2003). Furthermore, a study conducted in Ghana attested that the *Ababeletisi,* also known as traditional birth attendants, do not share the pregnancy status of a female. Secret signs of pregnancy, such as a growing abdomen, are obvious to protect both mother and baby from any bad spirits (Aziato & Omenyo 2018).

In some cultures, the expecting mothers are also given a herbal medicine called *mbita* (which constitutes boiled herbs). This mixture is consumed by expecting mothers in an effort to protect the unborn baby from any sorcery during labour. The *mbita* is also called *Scerlocaya caffra* in Western medicine (Ngomane & Mulaudzi 2012). In other studies, the females would use eucalyptus oil drops put in water or mixed with *ivimbela* (white ointment), as known in isiZulu culture, as a means to chase away the evil spirits (Mudonhi et al. 2021).

Implications and considerations for health care practitioners

These findings suggest that childbearing females have beliefs associated with fear of evil spirits that may impede the childbirth process, thus also delaying seeking antenatal care. Thus, Western health care practitioners must know the possible reasons for delayed antenatal attendance and the increased rate of babies born before arrival (BBA).

The first stage of labour

During the first stage of labour, the traditional birth attendants will note that labour has begun. Once labour is confirmed, the traditional midwives would advise the childbearing female to bear down as soon as she feels the uterine contractions or labour pains are becoming stronger (Makoae 2000).

Vaginal examination during labour

The practice of vaginal examination varies across cultures. Often the practice is conducted to determine and confirm how far the head is from the perineum. The traditional birth attendants in KwaZulu-Natal often insert two to three fingers, sometimes bare, into the vagina to feel for the lump which would indicate the foetal head (Makoae 2000). In Lesotho, the traditional birth attendants put fingers to determine the level of the head; if fingers go in completely, the head has not yet descended. In Ghana, the traditional birth attendants furthermore assess whether the membranes are intact or ruptured by checking if it is near the vaginal opening which indicates that the female will give birth soon (Aziato & Omenyo 2018). The authors note that the same practice of assessing cervical dilatation is practised in both traditional and Western practices. It is imperative to note the risk of infection and puerperal sepsis; thus, the health care professional should train traditional birth attendants on safe childbirth practices.

Pain relief during labour (*ukudambisa izinhlungu ngesikhathi sokubeletha*)

The females sometimes experience unbearable labour pains. The Vatsonga traditional birth attendants, in these instances, would prepare a medicine called *Xirhakhari*, where the herbs are boiled. This medicine helps relieve excessive labour pains (Ngomane & Mulaudzi 2012). In another study, it is suggested that the female should place the *snuff* on her doorstep as a practice that will inform the ancestors that she is about to go into labour (Masilo 2022). Furthermore, this practice is also believed to assist in ensuring that the females experience only mild uterine contractions throughout the stages of labour (Ngomane & Mulaudzi 2012). The practice of using the *snuff* is equated to the non-pharmacological management of pain that will reassure the females and promote pain relief. In Ethiopia, the traditional birth attendant applies butter to the female's abdomen as a form of pain relief and to accelerate the labour process (Kitila et al. 2018). The females are also encouraged to dance as a way of facilitating the labour process and reducing the associated pain.

Implications and considerations for health care practitioners

The findings suggest that health care professionals utilise non-pharmacological pain relief remedies during childbirth which allow the use of natural resources in efforts to improve the birthing experience of the female.

The second stage of labour

The second stage starts when the cervix reaches full dilatation (10 cm) and ends with the delivery of the baby. The following practices are performed by the traditional birth attendant in preparation for the birth of the baby.

The maternal birthing position practices

In rural Uganda, the females express their concern regarding the mode of delivery utilised in the health care facilities (Atukunda et al. 2020). Most females prefer to choose their birth position; however, in health care facilities, they are restricted from adopting the lithotomy birth position. In contrast, during home births, they are allowed to adopt a birthing position that comes naturally to the female (Atukunda et al. 2020).

Studies support the notion that females should make an informed decision on the type of birth position of their choice; however, this right is sometimes overlooked within Western medicine (Mselle & Eustace 2020; Musie, Peu & Bhana-Pema 2019). Since ancient times females gave birth in various positions such as semi-sitting, upright position, squatting, kneeling, all fours position and left lateral position, as it was a common birth position that usually occurred in a home-delivery setting (Zileni et al. 2017, p. e2).

However, this is not the reality in health care facilities where the midwives who are considered skilled birth attendants are not giving the females the choice of birth position as highlighted by the maternal guidelines of South Africa. Midwives continue to routinely position females in supine positions during both the first and second stages of labour despite the evidence that supports various birth positions (Musie et al. 2019). Most traditional birth attendants use the upright, kneeling or standing birth position as it is associated with greater pelvic outlet diameters and improves the effectiveness of uterine contractions, allows labour to progress quicker and better neonatal outcomes such as good Apgar scores and reduces the risk of foetal distress (Currie 2016; Musie et al. 2019). It is about time midwives recognise the importance of traditional practices related to birth positions.

Practices during the third stage of labour

Some traditional birth attendants in Kenya indicate that the placenta with its membranes needs to be delivered within five minutes after the birth of the baby. If not delivered, they massage the mother's abdomen (Lefeber 1994). Furthermore, in Ghana, delayed cord clamping is mainly performed to free the baby from spirits (Aziato & Omenyo 2018). This practice is also followed in Western medicine as an evidence-based practice that is associated with optimal neonatal outcomes. Further, the study added that the female should avoid wearing tight clothes during pregnancy as this will cause umbilical cord complications (Aziato & Omenyo 2018). It is imperative for health care professionals to know about the traditional practices and beliefs associated with the third stage of labour.

Practices associated with placenta delivery and discarding the afterbirth

A study conducted in Ghana confirms that traditional birth attendants give females a bottle to blow in, as this helps with the delivery of the placenta. After the expulsion of the placenta along with its membranes, the female is given a choice to take the placenta for rituals and cultural practices (Aziato & Omenyo 2018). Most females, in respect of their traditional beliefs, take the placenta home and bury it in their yard. In contrast, other societies in Ghana indicated that the placenta might be burnt or discarded in the river (Aziato & Omenyo 2018). It is believed that practices of discarding the placenta should be practised with full caution, as acts of sorcery can be performed if the person comes in contact with the vaginal blood on the placenta. This could also cause premature death of the baby and future miscarriages (Aziato & Omenyo 2018). The placenta needs to be properly discarded. If this is not done, evil people may use the placenta to harm the baby. Thus, medical health care professionals need to give the female a choice of how to discard the placenta.

Practices to manage abnormal labour

Labour precipitation

The Batswana females are given a herbal medicine called *makgorometša* to drink. This medicine results in the initiation of precipitated labour. This is to ensure that the females give birth rapidly. Other indigenous practices followed to induce labour include removing the expecting mother's clothes from the wardrobe at home, as this might facilitate the labour process (Mogwane et al. 2015).

Prolonged labour

Batswana of the Northwest Province in South Africa believe that a person who is envious and jealous of someone's pregnancy can invoke an evil spirit to cause harm to the female or the foetus, which is known as *dikgaba* (Chalmers 1990; Du Preez 2012; Van Der Kooi & Theobold 2006). The *dikgaba* means to harm or to cause heartache to others (Ademuwagun et al. 1979). The English *dikgaba* or *kgaba* is known as *Rhoicissus tridentata*. It is believed that *dikgaba* [a grudge] may cause complications such as abortion, stillbirth, maternal death and prolonged or difficult labour (Du Preez et al. 2012; Hlatshwayo 2017). The traditional birth attendant will then prepare a herbal decoction called *kgaba* to manage *dikgaba* (postdates and prolonged labour) (Van Der Kooi & Theobold 2006). Studies by Hlatshwayo (2017) and Van Der Kooi and Theobald (2006) indicate that the decoction is a mixture of the ostrich eggshells, baboon urine and herbs.

Practices to prevent prolonged labour include the husband of the pregnant female not tying a belt around the waist. The belief is that this may prolong the birth. The females are also advised not to sleep during the day nor accompany visitors when they leave, which is a prevalent practice in most African communities in South Africa, as this may also cause prolonged labour (Mothiba et al. 2015).

The VhaVenḓa say that prolonged labour is caused by the female not abiding by the following beliefs. *Mudzadze onopfelekeza vhayeni* means that the female is not supposed to bid farewell to the visitors (Mothiba et al. 2015). In the Limpopo province, traditional birth attendants advise the females to slaughter a chicken, burn its legs to ashes and then eat the powder and drink warm water. This practice is believed to assist females and initiate labour progress (Maimbolwa et al. 2003; Mogawane, Mothiba & Malema 2015).

Implications and considerations for clinical health care professionals

It is imperative for clinical health care professionals to be aware of the traditional practices that may cause expecting mothers' labour to occur rapidly. Detrimental practices can be addressed to avoid further harm to the mother and her unborn baby. Appreciation and reinforcement of positive cultural practices by health care workers will ensure compliance by pregnant females and their families.

Indigenous after-birth practices known as *vutswedyani* in Xitsonga

Traditional birth attendants and family members play an important role during *vutswedyani* (after-birth care referring to the postnatal period) among Vatsonga. In this culture, *vutswedyani* starts immediately after the birth of the placenta and membranes (Ngunyulu & Mulaudzi 2009). The placenta and membranes are also called *gula* in Xitsonga and *ungubo yomtwana* in isiZulu. This period continues until the female has her first menstruation after birth. The duration of after-birth differs according to individual females' menstrual cycles. Therefore, the after-birth period for the majority of females ranges between six and 12 weeks from an African perspective. The after-birth period is known, named and understood differently by people according to their cultural backgrounds and languages. For example, in Xitsonga it is called *vutswedyani* (postnatal period) and the postnatal mother is called *ntswedyani* or *umdlezani* in isiZulu.

Immediate indigenous practices after home birth

Indigenous practices on how to care for the mother and the baby after birth differs according to countries, regions and even communities. Each country

employs indigenous practices according to its cultural beliefs, norms and values. In rural KwaZulu-Natal, immediately after delivery of the placenta, the traditional birth attendants tie the cord with a clean string and cut it with a new razor blade (Ngunyulu & Mulaudzi 2009). Females are encouraged to bring their new razor blades for cutting the cord. This is done because sharing or reuse of razor blades is prohibited and can prevent cross-infection (Ngunyulu, Mulaudzi & Peu 2015).

Indigenous practices and health care promotion

Promotion of health care and well-being

Health care promotion is also called *nsivela mavabyi* in Xitsonga. Traditional birth attendants in some communities promote the health and well-being of mothers and babies during after-birth care. An hour after delivery, the mother and the baby are kept in the hut of the mother-in-law. The main purpose is to protect them from the evil spirits (infections), which are believed to be possibly brought by people coming to see the mother and the baby. As in most African cultures, community members, neighbours and close relatives usually visit the family once they receive the message that the baby is born. This is a common way of showing support. So, to reduce and control the number of people, they allocate the trusted traditional birth attendant to provide special care to the mother and the baby. The selected elderly female or traditional birth attendant should be aged 50 years or above and reached menopause. The traditional birth attendant should be known by the chief and the community as a person actively involved in the care of females during pregnancy *vuyimani* (labour), *ku lumiwa* (peuperium) vutswedyani (after-birth). Furthermore, she should not be sexually active because it is believed that might bring evil spirits (meaning that they are highly infectious) (Ngunyulu & Mulaudzi 2009). The selected granny is expected to assist the mother with household chores so that she gets time to rest and recover physically and emotionally from pregnancy, labour and birth injuries or stress. Similarly, in Nigeria, after-birth mothers are isolated and relieved from all household chores (Sulayman & Adji 2019). This helps to restore a female's energy and ensure a speedy recovery. During the confinement period, the mother is also given warm food, including traditional soft porridge called *xidlamutana* in Xitsonga or *umdoko* in isiZulu, which is believed to promote milk production, crucial for baby feeding. This shows that the family members and traditional birth attendants know the value of health care promotion and disease prevention during the after-birth period.

Implications and considerations for health care practitioners

It is crucial for midwives to be aware of the knowledge and skills of family members and traditional birth attendants so that they consider working with them during after-birth care.

Prevention of sub-involution (*makhuma*)

For the uterus – known as *xivelekelo* in Xitsonga and *isibeletho* in isiZulu – to return to its normal state, some traditional birth attendants use a mixture of water, salt and *munywana*, which is also known as 'young Jew's mallow' and perform *ku thova*; *ukuthoba* [warm water compresses] on the lower abdomen. This practice of warm compressions is done daily and is repeated until vaginal bleeding stops and the *xivelekelo* [uterus] returns to its non-pregnancy state.

Other traditional birth attendants advise the mother to closely observe and urgently report the bad smell of the vaginal blood during after-birth and continuously guard the mother's body for changes in colour and general weakness. It is believed that before the uterus returns to its normal pre-pregnancy state, the mother is at risk of having 'evil spirits' (acquiring infection), which in most instances leads to *makhuma* [sub-involution], and consequently puerperal sepsis (Ngunyulu & Mulaudzi 2009). This shows that traditional birth attendants are aware of the importance of early identification of problems/risks and rapid response to prevent complications.

Implications and considerations for health care practitioners

It is deemed crucial for the health care professional to be knowledgeable of the traditional management and prevention of sub-involution.

Management of *tśhilwane/chiloane* after-birth pains

Traditional birth attendants know the different methods of preventing sub-involution and are experts in the management of pains that occur after the birth of the neonate. Once the female reports experiencing postnatal abdominal pains, they boil *mukhusu*, which is a dried indigenous vegetable for almost 30 minutes to an hour to ensure that the vegetable releases all the nutrients. After boiling, they allowed the boiled *mukhusu* to cool down until lukewarm; then the soup is drained and given to the postnatal female to drink every morning before she eats breakfast. She is advised to continue drinking until the after-birth pains stop (Ngunyulu & Mulaudzi 2009). Some traditional birth attendants prefer to use a mixture of water, salt and *munywana*; they boil the mixture first, then allow it to cool down until it is warm and do abdominal

compresses twice daily until the after-birth pains subside (Ngunyulu & Mulaudzi 2009).

Delayed resumption of sexual relations

Indigenous practices advise females to delay the resumption of sexual activities for several reasons, which include giving the female the opportunity to recover completely from pregnancy and labour-related injuries and to return to the previous pre-pregnancy state without disturbances (Ngunyulu & Mulaudzi 2009). They believe that the uterus of the mother is still highly favourable for conception, should the couple decide to have sexual relations before the mother starts to menstruate after birth (Ngunyulu & Mulaudzi 2009). Furthermore, some cultures allow the after-birth female to return to her hut when she starts her first menstrual period after delivery. It is believed that the first menstrual period after delivery is a clear indication that the reproductive organ systems, more especially the uterus and the related structures have completely recovered from the pregnancy, labour and birth-related injuries (Ngunyulu & Mulaudzi 2009). When the mother starts to menstruate, she needs to communicate to the traditional birth attendant and the mother-in-law by waking up very early in the morning; in ancient times, the mother was supposed to smear cow dung in the hut where she resides. Smearing cow dung was the traditional way of keeping the huts clean and free from dust. When the allocated traditional birth attendant and mother-in-law see this, they know that the mother is ready to go back to her room.

Recommendations

Indigenous beliefs and practices among Africans are often at crossroads with Western practices. Fortunately, an African male cannot be separated from indigenous beliefs and practices. It is therefore important for health care practitioners to be aware of these practices and collaborate with traditional birth attendants to meet public health care expectations.

To meet the public health care expectation, midwifery curriculum and training content should have components of indigenous practices and cultural practices in addition to the existing Western health care practice, and it should be preferable to use both health care system approaches during training to produce midwifery graduates that are ready to meet the cultural health care needs of diverse pregnant females living in various African countries.

It is crucial for midwives to have adequate knowledge of indigenous practices to make a comprehensive clinical judgement when dealing with mothers and babies from diverse cultural backgrounds. This knowledge will enable midwives to identify indigenous practices that might place the health care of the mother and their babies at risk.

Conclusion

The chapter documented indigenous beliefs and practices during pregnancy, labour and after-birth in Africa, which are still in practice despite the overshadowing of Western practices. The documented practices provide insights into the many behaviours of females during pregnancy, labour and after birth. In addition, the knowledge of these beliefs and practices will equip health care practitioners with the needed tools to combat conflicts that may arise between health care practitioners and pregnant African females.

Glossary

- ***nsivela mavabyi*:** Refers to health care promotion
- ***ababeletisi*:** Referred to as traditional birth attendants or indigenous midwives in Isizulu
- ***amadlodzi*:** A word for the ancestors
- ***amakhosikazi akithi*:** Grandmothers or elderly females who have passed menopause
- ***demamhandwe*:** A wild herbal plant
- ***dikgaba*:** Harm or heartache
- ***gula*:** Placenta and membranes, known as *ungubo yomtwana* in IsiZulu
- ***isigaba sokuqhala sokubeletha*:** Progress of labour or childbirth
- ***isihlambezo*:** A herbal concoction used to precipitate labour
- ***kgaba*:** Medicine to manage *dikgaba*, postdates and prolonged labour
- ***maendlelo ya ndzhavuko/imfundiso zesintu*:** Indigenous practices of childbirth
- ***mahlayiselo ya Vasungukati*:** Midwifery health care system
- ***makhuma*:** Sub-involution of the uterus
- ***mbita*:** Herbal medicine used to protect against evil
- ***tshilwana*:** Post-birth abdominal pains
- ***ukubeletha*:** Labour or childbirth
- ***ukuhlamba***: To cleanse the ceremonially for protection
- ***ukukhulelwa/nyimba*:** Pregnancy
- ***vutsedyani*:** Afterbirth
- ***vutswedyani*:** Postnatal period
- ***xirhakarhani*:** Indigenous analgesic used to ease labour and prepare for labour

Chapter 7

Provision of neonatal care: An African indigenous perspective

Khathutshelo G. Simane-Netshisaulu
Department of Advanced Nursing Science,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa

Rachel T. Lebese
Department of Advanced Nursing Science,
Faculty of Health Science, University of Venda,
Thohoyandou, South Africa

Patience M. Tulelo
Department of Midwifery Nursing Science,
Gauteng College of Nursing,
Pretoria, South Africa

Abstract

Child development outcome is determined by the quality of neonatal care provided. Globally, mother-baby relationships and caring for neonates are conceptualised based on Western culture. However, in African indigenous cultural systems, certain practices and treatment modalities are practised during the neonatal period. The purpose of this chapter is to focus on the documented indigenous beliefs, practices and treatment modalities regarding neonatal care. Confinement of a mother and a neonate for at least a month following birth is strictly recommended in African traditions. During this

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period, only a selected few are allowed in the room where the mother and the baby are. Failure to comply with this practice is not acceptable *zwi a ila* and can make the baby sick *u kanda nwana*. These practices are of great importance for the promotion of bonding, maintenance of the baby's warmth as well as prevention of cross-infection. Indigenous African cultures have treatment modalities that are routinely administered; these practices are not formally documented. Knowledge and understanding of indigenous neonatal care practices by health care professionals might create awareness of such practices in the communities that they serve. This will enable health care practitioners to provide support, learn and respect the beliefs and practices that are beneficial to neonatal health and alert communities regarding those practices that are harmful. This may be achieved through effective collaboration between health care providers and traditional birth attendants.

Neonatal health

According to the World Health Organization (WHO), a neonate is an infant during the first 28 days following birth (WHO 2016). This period is considered critical because a neonate is at the highest risk of dying. Currently, the number of neonatal deaths in the world is unacceptably high, despite the mortality rate being within the sustainable development goal (SDG) target (Rhoda et al. 2018). According to Gandhi et al. (2014) neonatal care practices contribute to the deaths of newborn babies during the first 28 days following birth.

In Africa, there are countries where females still deliver babies at home. Such deliveries are supervised by either experienced midwives or elderly females within the family. The deliveries are done by following the indigenous knowledge, beliefs and practices influenced by local culture and traditions. However, some of the indigenous neonatal care practices may have negative implications on neonatal health. Consequently, community members need to be made aware of how to identify life-threatening signs in newborn babies (Gandhi et al. 2014; Otieno et al. 2013). There are, however, traditional and cultural practices that may be beneficial to neonates. Effective collaboration between health care professionals and traditional birth attendants is therefore necessary for addressing neonatal care practices (to prevent harmful practices that may negatively affect neonatal health) and to promote good practices.

The primary purpose of the chapter

The purpose of this chapter is to formally document and report on the positive and the negative indigenous practices and treatment modalities regarding neonatal care. It is of paramount importance that health care professionals have indigenous knowledge and understanding regarding neonatal care practices. This will enable them to learn, support as well as

adopt good practices. On the other hand, it will also identify practices that may pose threats to neonatal health.

Immediate care at birth

This is the care provided to a newborn baby at birth. In rural and remote Africa, pregnant females still deliver babies at home; whereby deliveries are conducted by the grannies, experienced family members or traditional birth attendants. Based on tradition and culture, certain neonatal care practices are implemented as rituals immediately at birth by either an elderly female in the family or a traditional birth attendant who conducted the delivery. The rituals are aimed at saving the newborn baby's life.

In Niger Delta, a district of Nigeria, babies who fail to cry immediately at birth are given traditional stimulants such as *ogogoro* (a traditional gin) to drink, and it is believed that this will stimulate the baby to cry. Palm wine is also splashed on the newborn baby's face and body to make the baby cry at birth (John et al. 2015).

According to Nigerian tradition, a newborn baby is thrown into the river as it is believed that the neonates have to be introduced to the water so that they may get used to water; and this practice will enable the child to swim without difficulties early in life. The practice is commonly done in those villages situated next to the rivers. Traditional birth attendants do not worry much about newborns drowning because they believe that newborns are used to swimming, as they have been swimming in the mother's uterus and are brought out of the water immediately (John et al. 2015).

According to John et al. (2015), in some rural parts of Nigeria, hair threads or a stick of an Areca tree are used for cutting the umbilical cord. The reason for such a practice is the belief that the cord cut with a razor blade takes longer to dry and fall off and the umbilicus protrudes after healing. It is believed that an umbilical cord cut with either the hair threads or an Areca stick heals and dries naturally and prevents bad odour from emanating from the cord. After cutting the cord, traditional birth attendants rub the umbilical cord with coarse table salt. This is done as it is believed that the practice helps in the prevention of a bad smell coming from the cord at a later stage (John et al. 2015).

In Tanzania, Ghana and Senegal, traditional birth attendants take long before drying and wrapping the newborn at birth, predisposing the baby to hypothermia. The reason for the delay is that in most cases, after the birth of the baby, traditional birth attendants are preoccupied with the delivery of the placenta, and no one is there to assist with the cutting of the umbilical cord (Bazzano 2006; Hill et al. 2010; Niang 2004; Shamba et al. 2014).

In Ethiopia, priority is given to the delivery of the placenta because it is a taboo to provide care to a newborn baby until the placenta is buried; this practice exposes the baby to hypothermia as immediate care is not given in the form of drying and wrapping of the newborn baby (Amare 2008).

Implications and considerations for health care practitioners

There is a clear demonstration that most traditional birth attendants and mothers in African traditions still lack knowledge and understanding regarding some traditional practices that are performed immediately after the birth of a newborn baby, which poses threats to neonatal health.

Confinement of the mother and the neonate

In most patriarchal societies, the postpartum is a period during which the female and the newborn baby are unclean; and, therefore, seen as a threat to others. On the other hand, the female and the newborn baby are considered vulnerable, implying that the environment around them becomes dangerous for them. The fact that a postpartum mother and her newborn are considered unclean and vulnerable results in them being ritually secluded or isolated and confined in a separate room for a specified period following the birth of the baby. During this period, the mother is expected to stay in bed and is excluded from performing household chores. This gives the mother enough chance to rest and take full responsibility for neonatal care. The practice is beneficial for both the mother and the baby because not only does it promote rest for the mother, but it promotes maintenance of the baby's warmth, promotion of bonding and feeding on demand as well as prevention of cross-infection (Bee, Shiroor & Hill 2018; Eberhard-Gran et al. 2010; John et al. 2015).

In the Vhembe district of South Africa, mothers and their neonates are placed in confinement for fear of *mirunzi ya vhathu* [evil spirits carried by people] as it is believed to be one of the common unnatural causes of neonatal illnesses, which are a serious concern to the mothers. In some families, confinement extends to abstinence from sexual relations between the parents of the neonate. The length of confinement varies according to the family. The period is two weeks in less strict families and three months in stricter families. Even if three months of confinement is preferred, the mother is allowed to leave her room and do some housework or even go to work, but the neonate must remain confined and away from people who are not an immediate family (Tulelo 2021). An investigation in Botswana and Tanzanian related to abstinence from sexual relations between parents of the neonate was found to have similar results (Kayombo 2013; Mwape et al. 2018; Rempel et al. 2019). This preventive strategy is thought to improve neonatal weight gain while protecting both the neonate and the mother from additional ailments brought by evil spirits.

Rooming-in

In Nigeria, the postnatal female and the newborn are kept in isolation in a special room ('fattening room') for 2–3 months. During this period, the mother's responsibilities include eating, resting and taking care of the baby (Eberhard-Gran et al. 2010; John et al. 2015). A similar custom is practised by the Masai people in Tanzania and Kenya. A postnatal female and her baby are isolated, and the main duty of the mother is to eat abundantly (Eberhard-Gran et al. 2010). During this time, the only people who can gain entrance into the mother's room are immediate family members and the elderly who are providing care to the mother and the baby (Bee et al. 2018).

In rural Zambia, only selected people can touch and hold the baby. These include the grandmothers and other elderly people in the family. All single and or divorced people are not allowed to touch or hold the newborn baby for fear that they might have engaged in sexual intercourse (which is considered dirty). In that case, it is believed that the newborn baby may die or suffer infertility in the future (Buser et al. 2020). In Niger, the mother and her newborn baby are kept in isolation; and can only leave the room when the umbilical cord has fallen off. The reason for this practice is the protection of the newborn from evil spirits and those with evil intentions (John et al. 2015).

Maintenance of the infant's body temperature

Confinement of the mother and baby in their room for weeks (or months, depending on the culture), is a good practice that promotes thermal care. This helps to keep the baby warm and free from cold and draughts that may cause hypothermia (*nwana o dzhenwa nga phepho* in Tshivenḓa) to the neonate, resulting in death (Eberhard-Gran et al. 2010). Keeping the baby away from draughts, application of oil all over the body, wrapping the newborn baby with blankets and warming the place where the female and the neonate are accommodated are common beneficial traditional African practices (Bee et al. 2018). Mothers in Niger are encouraged to stay indoors with the newborn baby for a stipulated period after giving birth. This is done to keep the baby warm and avoid exposure to cold (John et al. 2015).

Though the mother and the neonate are kept indoors following delivery which is beneficial for thermal care, literature based in Nigeria, Uganda, Ghana, Zambia and Malawi reveal that during delivery, traditional birth attendants leave the newborn baby exposed and unattended to, while attending to third and fourth stages of labour. This practice predisposes the newborn baby to a very high risk of neonatal hypothermia. The majority of the females were concerned that newborns were exposed to cold at birth because a lot of time elapsed before any attention was given to them. Maintenance of skin-to-skin contact between the newborn baby and the mother is a rare experience, and neither is a baby covered as traditional birth attendants are busy with the

mothers (Bee et al. 2018; John et al. 2015; Lunze et al. 2014; Ministry of Health [MoH] 2008; Rajith et al. 2010; Zimba et al. 2007). Ethiopians, Ghanaians, Nigerians, Malawians, Tanzanians, Zambians and Ugandans believe that a newborn baby should be kept in a heated room to avoid exposure to drafts and cold, which can make the baby sick (Amare 2008; MoH 2008).

Promotion of bonding

Traditionally, rooming-in during the initial stage of postnatal care is recommended, and this is beneficial for the promotion of bonding between the mother and the neonate. According to Eberhard-Gran et al. (2010), Bee et al. (2018), John et al. (2015), Hill and Flanagan (2020) mother–neonate bonding is vital as it provides the neonate's first model for intimate relationships and fosters a sense of trust, security and positive self-esteem. The quality of the bonding relationship between both directly impacts the long-term mental health of the mother and the neonate. The authors further stated that the type of bond established between the mothers and the neonates determines the growth of the children and the way they will interact with other people and will raise their children. Bonding between the mother and her newborn baby is also promoted in Niger's district of Nigeria. The mother and her newborn baby are encouraged to stay in a room so that they can get time to know each other and the baby can get used to the mother's body scent (John et al. 2015).

Prevention of cross-infection

Seclusion and confinement of the mother and the baby during the early postnatal period is considered beneficial for both the mother and the baby. Limitation of the number of family members, relatives and friends allowed to visit the mother and the baby minimises chances of transmission of infection to the neonate putting its life at risk (*u kanda nwana*), especially before the umbilical cord drops off.

Implications and considerations for health care practitioners

The seclusion of the mother and the newborn baby after delivery is beneficial for both parties. The practice promotes rooming-in, maintenance of warmth, promotion of bonding and prevention of infection to both the mother and the baby.

Feeding practices

Initiation of breastfeeding

Though it is advocated that the baby be breastfed immediately after delivery (within at least 60 min after delivery), most African traditions are still not in

support of the practice. Some traditional birth attendants and elderly members of the family believe in feeding a warm, soft porridge mixed with herbs [*tshiunza*] to a newborn baby at birth and breastfeeding later. In the study by Ngunyulu, Mulaudzi and Peu (2015), it is reported that a traditional birth attendant considers it a norm that after conduction of delivery, she prepares soft porridge for the newborn baby as she believes that the porridge will promote relaxation and accelerate growth.

According to Alebila (2019), most Ghanaians believe that breastfeeding is not supposed to be initiated until after the call of three Azans (calls for three Islamic prayer sessions). They believe that when babies are kept waiting for that number of hours without having been fed, they become strong as they are being trained to be patient in life. The practice is believed to prepare the baby to become a strong and patient adult.

Another reason for the delay in the initiation of breastfeeding is that breastmilk is believed to be bitter during the first few days after delivery and the mother needs to have a cleansing ritual in the few days after delivery. Provision of substitutes is made if the baby has not been fed for more than one day, otherwise, nothing is given during the first day (Aborigo et al. 2012; Alebila 2019; Tawiah-Agyemang et al. 2008).

Several studies conducted in Ethiopia, Tanzania, Malawi, Nigeria, Ghana, Senegal, Uganda and Zambia, report delays in the initiation of breastfeeding and the following reasons were advanced for the delay: mothers did not have milk during the first few days, which according to culture is not a problem as it is believed that it 'takes days for breasts to start secreting milk following delivery of a baby' (Aborigo et al. 2012; Oche, Umar & Ahmed 2011; Rogers et al. 2011).

- The babies were tired and not ready to feed.
- The babies were not showing any sign of hunger.
- The mothers needed to rest.

Another reason why Ethiopians and Tanzanians do not initiate breastfeeding within an hour after delivery is related to hygiene practices. It is believed that the blood of the mother, which is believed to be unclean, comes into contact with the baby at birth. Therefore, it is unhygienic for the mother to breastfeed before taking a bath. Both the mother and the baby should have a bath before the initiation of breastfeeding (Aborigo et al. 2012; Bee et al. 2018; Oche et al. 2011; Rogers et al. 2011).

In Uganda, Nigeria, Ethiopia, Malawi and Senegal, herbal concoctions are given as prelacteals to clear the bowels, clear and soothe the airways and throat and protect the baby against illness (Bee et al. 2018).

Newborn babies born in Ethiopia, Uganda, Ghana, Tanzania and Nigeria are fed with artificial feeds such as water mixed with sugar and milk

products when the mother does not have breastmilk (Aborigo et al. 2012; Bee et al. 2018; Oche et al. 2011; Rogers et al. 2011; Zimba et al. 2007). In Uganda, the practice followed is that if the baby is born hungry, the mother initiates feeding 'there and then' (but it is not clear as to how immediately after delivery). If the mother had something to eat before giving birth, the newborn baby is not hungry; therefore, there would be no need to initiate breastfeeding early (Bee et al. 2018; Eberhard-Gran et al. 2010; John et al. 2015).

Water or milk imbibed with the Koran is given to Muslim babies born in Senegal, Nigeria and Ethiopia, according to Muslim tradition; this is called *toxantal* water, and it is given to a newborn baby as an initial drink before feeding on the mother's breasts (Bee et al. 2018; Oche et al. 2011; Zimba et al. 2007).

Colostrum

In Ghana, colostrum is believed to have been contaminated with sex which causes abdominal pains in the baby; therefore, babies are not to be fed colostrum (Alebila 2019). In Uganda, Tanzania, Ethiopia and Nigeria, colostrum is said to be dirty, harmful and unhealthy and should therefore not be fed to the baby. Consequently, it is squeezed out of the breasts and discarded to avoid poisoning the baby. In Niger, instead of feeding the baby with colostrum, it is expressed and disposed of while the newborn is given water for the first three days after birth (John et al. 2015). The reason why colostrum is associated with dirtiness, harmfulness and being unhealthy is the yellowish colour (Aborigo et al. 2012; Bee et al. 2018; Oche et al. 2011; Rogers et al. 2011; Zimba et al. 2007).

Exclusive breastfeeding

Most African cultures do not consider exclusive breastfeeding as the best feeding option. It is believed that the baby who is exclusively fed breast milk suffers from hunger and cries continuously. According to VhaVenḓa, a very light and warm soft porridge with herbal concoctions (*tshiunza/khongodoli*) should be given as it is thought to be calming and satisfying to the newborn baby, thereby enhancing growth. This is confirmed by Ngunyulu et al. (2015) when they reported that in the Mopani district of Limpopo, infants who are only breastfed, suffer from colic and cry uncontrollably, resulting in fever. Therefore, breastfeeding should be preceded by the provision of a light soft porridge. In Mansa, the district of Zambia, the introduction of traditional porridge to a baby is done when the baby is about a month old. Soft porridge

mixed with traditional herbs is given to make the baby strong, healthy and free from getting sick (Buser et al. 2020).

In Ghana, a baby is given cow's milk mixed with honey. This is given to the baby because it is believed that the baby can never be satisfied with breast milk as it is watery. It is also believed that water mixed with shea butter and herbs makes the baby sleep longer. The baby is also fed with soft porridge (Alebila 2019).

Mothers and grandmothers in Niger do not support the baby being fed on the breast only. They believe that a neonate should be given a lot of water as the weather is hot. They believe that breastmilk does not quench thirst. Therefore, after breastfeeding, the baby is given water to quench their thirst (John et al. 2015).

☐ Implications and considerations for health care practitioners

It is evident that most traditional African communities need empowerment on the importance of observing safe feeding practices of neonates. These include initiation of breastfeeding within an hour after birth and the benefits of exclusive breastfeeding for the first six months. Traditional birth attendants, elderly family members and mothers are still not aware of the protective properties of colostrum. This explains why they squeeze it out of the breast instead of feeding it to the newborn baby. The dangers of the introduction of solids to newborns and those of giving herbal concoctions to newborn babies should be emphasised.

■ Initial infant bath

There seems to be a common belief among most African traditions that the initial baby bath should be done soon after birth. Mothers in East, West and Central Africa believe in immediate bathing of the newborn after birth because amniotic fluid has an unpleasant smell. They are afraid that if the baby is not bathed within an hour, the fluid may be absorbed into the baby's skin, causing a permanent foul body odour (Aborigo et al. 2012; Bee et al. 2018; Oche et al. 2011; Rogers et al. 2011; Zimba et al. 2007).

In Ghana, massaging the baby with shea butter before bathing is believed to make them fat and intelligent; and covering them tightly after a bath keeps the baby warm (Alebila 2019). Hot and cold water mixed with herbs is used alternatively for bathing the baby, with the belief that cold water makes the bones strong and enables the baby to withstand rain and cold weather later

in life, whereas hot water freshens and adds shine to the skin. During bathing, the newborn baby is folded like a smoked fish or a fowl so that they will become flexible when they grow up. After bathing, the baby is thrown up in the air and grabbed. This makes the baby strong and helps in the prevention of fainting (Alebila 2019).

Literature reveals that there is a common belief in Malawi, Senegal, Tanzania and Uganda that the initial baby bath should be done immediately (within 6 hours) following birth. The main aims for an immediate baby bath are (Aborigo et al. 2012; Bee et al. 2018; Oche et al. 2011; Rogers et al. 2011; Zimba et al. 2007):

- To clean the baby and remove dirt and odour.
- To make the baby comfortable, thereby promoting sleep.
- To remove vernix which is linked to sex as it is thought to be semen.
- To make the baby clean for visitors.

Ethiopians believe that bathing the baby within the first six hours after birth keeps the baby clean and free from odour. They also believe that bathing the baby immediately after birth makes the baby strong (Amare 2008). The fact that the newborn baby is born dirty, combined with the ritual pollution associated with childbirth, provides the basis for the immediate bathing of a newborn in the Niger Delta, a region of Nigeria. The elderly believe that the white layer of vernix on the baby's body is caused by the wrong food that the pregnant female was eating during the antenatal period or during labour and needs to be wiped off (John et al. 2015). Thereafter, the baby is bathed every day; and it is during bathing times whereby rituals such as the application of ointments (coconut oil and shea butter), massage, limb stretching and body moulding with warm water are performed before bathing. This is done to strengthen the newborn baby, soften the skin and relieve colic and stress (John et al. 2015).

Implications and considerations for health care practitioners

Health education must be given to mothers and the elderly members of the communities so that they may understand the physiology around vernix. The fact that newborn babies are delicate and unable to generate heat, which puts newborn babies at a very high risk of hypothermia, should be made clear to elders and mothers. The empowerment of the community members might enable them to understand why bathing should be delayed after delivery.

Umbilical cord care

It is a typical occurrence in Africa and elsewhere in the world that families opt to employ indigenous substances over those given biomedically by the health

care system (Bee et al. 2018). In the East Mamprusi District of Ghana, mothers and elderly family members do not consider sepsis a serious issue but are worried about the period the cord takes to drop. This is because they believe that evil spirits intending to harm the baby pass through the cord. Hence, everything possible should be done to make it drop within seven days, before a ceremony for naming the baby is conducted. A mixture of shea butter, salt and fowl faeces applied on the cord makes it drop off within three days after birth. This is followed by the application of shea butter mixed with powdered dry roots to promote wound healing (Alebila 2019). In some rural parts of Ghana, shea butter is applied to the umbilical cord for the following reasons (Aborigo et al. 2012; Bazzano 2006; Bee et al. 2018; Oche et al. 2011; Rogers et al. 2011; Zimba et al. 2007):

- to keep the cord soft and wet so that internal sores can be given enough time to heal.
- stop bad smells.
- reduces illness and death in the birth.
- facilitates the dropping of the cord, making the baby a normal human being.

In Zambia, grandmothers and mothers prefer the application of traditional plants and dust on the umbilical cord to facilitate speedy healing as well as falling off of the cord, which enables the mother and the baby to discontinue confinement. Common traditional herbs include pumpkin leaves and pumpkin flowers; some also apply the faeces of a rat (Buser et al. 2020). Substances are applied to the cord for the following reasons (see Table 7.1):

- lubrication of the umbilical cord so that it does not crack, which may lead to bleeding.
- prevention and treatment of infection.
- promotion of dryness and falling off the cord.

Nigerians apply several substances to the neonate's cord while still fresh when it has dried up and even when it has dropped; such substances include engine oil, palm oil, sieved wood ash, heated herbs and breast milk (especially colostrum). When the cord stump is completely healed, a coin is placed over the stump and tied in place to prevent protrusion of the umbilicus (John et al. 2015).

According to the VhaVenḓa and Vatsonga traditions, cow dung is applied to the umbilical cord before and after it falls off. It is believed that cow dung facilitates dryness and falling of the cord. Some VhaVenḓa females apply extracted pig (pork) oil onto the umbilical cord stump to facilitate its separation and prevent it from getting septic. When the umbilical cord has fallen off, some grandmothers prepare powder from a broken clay eating bowl (*tshidongo*) and mix it with pork oil. The substance is then applied to the umbilical area to promote healing and closure (Tulelo 2021).

TABLE 7.1: Substances applied on the umbilical cord in different countries and reasons thereof.

Country	Substance used	Reason for application
Ethiopia	Butter	The umbilical cord is considered a connection through which the external environment communicates with the internal environment of the neonate. Facilitation of immediate closure of the opening to prevent illnesses that may be caused by the entrance of air, water or other environmental substances is necessary; butter is therefore used for the following reasons: • Facilitation of dryness and detachment of the cord • Prevention of pain and bad smell • Protection of the cord from infections and help to heal (Otieno et al. 2013; Rogers et al. 2011; Warren 2010).
Uganda	Powder, salty water, or herbs	• Promote dropping of the cord which promotes the mother's health thereby enabling her to attend to the household routine. • Dropping off the cord promotes neonatal health and facilitates sleep (Aborigo et al. 2012; Bee et al. 2018; Lassi et al. 2014; Oche et al. 2011; Rogers et al. 2011; Zimba et al. 2007).
Senegal	Cooking oil or herbs	Facilitate dryness and falling of the umbilical cord, thereby promoting the baby's health (Bee et al. 2018; Opara et al. 2012; Otieno et al. 2013; Rogers et al. 2011; Warren 2010).
Malawi	Butter, powder and herbs	• Accelerate dropping of the cord thereby shortening the confinement period, minimise bleeding and infection by keeping the cord soft and moist. • Cord dropping is also considered important because it is believed that once it is off, the neonate has become protected from illnesses and all those who have evil and negative motives against the neonate's life (Bee et al. 2018; Zimba et al. 2007).
South Africa	• Cow dung • Pork oil • Powdered substance	• Drying of the umbilical cord stump • Quick detachment and prevent sepsis of the umbilical cord stump • Encourage healing and closure of the area where the umbilical cord stump detached (Tulelo 2021).

Comforting a crying infant

In most African traditions, crying is associated with hunger, and in that case, the baby will be overfed, resulting in abdominal discomfort, which will aggravate the condition. According to John et al. (2015), in the Niger Delta, excessive crying of the baby is associated with serious problems that require traditional attention. A baby who cries excessively is believed to be experiencing discomfort or seeing frightening things (such as ghosts and evil spirits). Practices such as cuddling, stroking them softly, rocking gently while placed on the thighs as well as throwing them up in the air may make them stop crying. However, if crying persists, separation rituals and a 'feast' are conducted, as a baby might be seeing ghosts and may be tormented by evil spirits (John et al. 2015). In this ritual, rice is cooked the traditional way and palm oil is added. Biscuits, soft drinks, groundnuts and fruits are provided and children under five years old are invited to eat with their fingers from a common tray. After the meal, every child rubs the baby's body with their unwashed fingers and hands and the baby is not bathed till the following day (John et al. 2015).

It is common practice for the VhaVenḓa that a baby who cries excessively even after having been fed is interpreted as crying for the name of one of the ancestors who have already died. A ritual is performed whereby the grandmother will keep on calling the names of the ancestors one by one until the baby stops crying. If the baby stops crying after a particular name is called, it is believed that the ancestors and the baby are satisfied with the announced name; therefore, the baby will be given the name of the ancestor, and when called, the crying stops.

Protective measures

In most indigenous African traditions, it is believed that illnesses and health care problems are caused by sorcery and evil spirits. Therefore, a lot of traditional practices and rituals are performed to ward off sorcery and evil spirits that cause illness, thereby protecting the baby. These include traditional incisions, the use of charms and amulets made from different substances with incantations made over them, and the use of leaves, roots and bark of certain herbs which are prepared as concoctions or burnt in the room where the child sleeps (John et al. 2015).

Common practices believed to be able to ward off evil spirits include:

- Preparation of herbal juice for the baby to drink.
- Rubbing the baby's body with palm kernel oil.
- Cold herbal enema is given every two weeks.
- Skin incisions are made by a traditional healer so that bad blood can be released, and then gunpowder and herbs are applied to the incisions.
- Charms and amulets are tied around the waist and upper and lower arms (John et al. 2015).

In Ghana, when a baby who is light in complexion or big in size is born, people with evil spirits become jealous and plan to kill the baby; thus, certain protective practices are performed as rituals for the baby. *Nangbantori* (bitter mouth) is made, whereby marks are drawn on the door of the room in which the mother and her neonate are accommodated to prevent evil spirits from causing any harm to them. A charcoal fire is also made in the room where the mother and the baby are staying; herbs are placed in the fire and the baby is made to inhale the smoke. 'Mercury is poured over the head of the baby to repel evil spirits. A Koran, needles and a knife are placed under the pillow of the baby' (Alebila 2019). The mother-in-law prepares a special concoction which is given to the newborn baby as a way of welcoming them into the family and protecting the baby from evil spirits. The baby is considered a qualified and safe member of the family only after having drunk the concoction. They also emphasise that a newborn baby should not be taken outside the home premise before the 'child naming' ceremony is conducted, for they believe that it is difficult for evil spirits to harm a baby who has a name. The *vobeo* [bad leaf]

herb is mixed with garlic and is added to the baby's bath water. In the case of a boy, the baby is bathed in this mixture for three days, but for a girl, four days should suffice. Ghanaians believe that witches are afraid of the smell of garlic; therefore, when it is added to the bath water with herbs, the baby is definitely protected (Alebila 2019).

According to Buser et al. (2020) and Kayombo (2013), among the Lundazi, Mansa and Chembe of Zambia, certain rituals are performed to prevent and protect the baby from coughing and contracting pneumonia. Fire is prepared in the house where the mother and the baby stay and traditional herbs are placed in the fire. Parents engage in sexual activity. Thereafter, semen (referred to as sperms) will be spread on the joints of the baby. Then, the baby is passed back and forth over the fire, expecting them to inhale the smoke, which will clear the lungs and avert cough. The ritual is expected to strengthen the baby and protect them from coughing (Buser et al. 2020; Kayombo 2013).

According to Tulelo (2021), in the VhaVenḓa tradition, a traditional health care practitioner or an indigenous knowledge holder is consulted for the performance of the *mithuso*, a commonly practised ritual. The practice is claimed to be 'assisting a neonate to thrive', protecting it from those with evil intentions as well as protecting an infant from environmental harm at home after discharge from the hospital. It is believed that if a neonate meets with people who use *muthi* and practice witchcraft, it becomes afflicted with evil spirits and will therefore become sick. Various plants and traditional remedies are used by indigenous knowledge holders or traditional health care practitioners during *mithuso*. Some of them are boiled in water and fed to the newborn. The traditional medication used for *mithuso* could be plant roots or leaves, animal fat, skin or dung or amulets for the neonate to wear on the wrist or waist (Tulelo 2021). Incisions are made on the anterior fontanelle by a traditional healer, and substances are applied to the incised area. Similar practices are prevalent in Tanzania, where mothers and caregivers use traditional remedies to protect neonates from illnesses supposedly caused by evil forces or spirits (Kayombo 2013).

Implications and considerations for health care practitioners

It is evident that traditional birth attendants, elderly members of the family and mothers in most African traditions need empowerment on the dangers of making incisions and applying substances to the incised area. This practice could cause infection and even sepsis in the area. Administration of herbal concoctions to neonates is not safe because of the nonstandardisation of dosages. Overdosing a neonate with herbs might cause toxicity and gastrointestinal problems. Smoke inhalations should also be practised with caution as they may cause respiratory problems for the neonate. Rituals for

the provision of comfort and protective measures for newborn babies may pose threats to neonatal health.

Treatment modalities during illnesses

Jaundice

Traditions and cultures have different insights and modalities regarding the management of some ailments. In the Niger Delta, neonates with jaundice are given sweetened water and babies are also exposed to sunlight to clear jaundice. Herbal juice is administered in the eyes of the neonate as it is believed that it reduces the yellowish discolouration. In some instances, garlic cloves are pinned on a necklace that is prepared for the neonate to put on, believing that the drying up of garlic cloves is an indication of the disappearance of jaundice. The necklace is worn for seven days. If the neonate still presents with jaundice symptoms after the cloves have dried, hospitalisation is then considered for the management of neonatal jaundice (John et al. 2015).

Diarrhoea

In the case of diarrhoea, sips of a mixture of 'native chalk' melted in water are given to a neonate. It is believed that the concoction will harden the stools, thereby stopping the diarrhoea (John et al. 2015).

Convulsions

Palm kernel oil and herbal juice are administered in the eyes of a neonate with convulsions. 'Foot roasting' (placing the feet of a neonate next to the fire during convulsions) is also done as a treatment measure for convulsions. This is believed to be effective in keeping the feet warm, thereby preventing the child from 'seeing demons' during convulsions (John et al. 2015; Peterside, Duru & Anene 2015).

According to the VhaVenḓa, neonates have the natural ability to sense events occurring in the environment, such as animal sounds, which can adversely affect the neonate. When the *mithuso* ritual is performed, it also includes a procedure to prevent the neonate from experiencing convulsions or fits when baboons bark in the mountains or the forests. This kind of convulsion or fits is referred to as *a thavha*, loosely translated as 'things of the mountain', referring to baboons. It is believed that a neonate who did not go through the *mithuso* ritual will experience convulsions whenever a baboon barks from the mountain or in the forest (Tulelo 2021).

The VhaVenḓa also believe that neonates can be affected by the bark of a baboon to the point of having high temperatures and convulsions. To prevent

this from happening, the traditional health care practitioner performing *mithuso* for the neonate must add baboon dung and skin to the concoction to prepare a herbal medicine that the neonate will inhale. The procedure is completed by throwing neonates on top of a roof of a thatched hut and catching them with *luselo* (a large indigenous tray made from reeds) as they come rolling down. In the case of a neonate who experiences convulsions before *mithuso*, the same procedure of throwing the neonate on top of a hut is performed. It is believed the practice is the solution to the problem of neonatal convulsions. The need to prevent convulsions is emphasised because families believe that the neonate could suffer irreparable harm later in life. This may include mental retardation or madness should they suffer from convulsions repeatedly (Tulelo 2021).

Neonatal infections

Several neonatal infections are treated with the mother's breast milk. These include infection of the eyes, infection of the umbilical cord, redness of the genitalia and sore buttocks resulting from a nappy rash (John et al. 2015; Opara et al. 2012).

Cough

When the baby has a cough, the father is suspected of having had sexual relations with another female (other than the wife) and touching or holding the child when they returned home. As a treatment measure, the parents should engage in sexual intercourse; the father should ejaculate semen in his palm and apply it to the neonate's body (Bee et al. 2018; Buser et al. 2020).

Sunken anterior fontanelle (*ngoma)*

Ngoma (anterior fontanelle) presents with a wide, sunken and pulsating fontanelle. In such cases, an indigenous knowledge holder is consulted to cure the neonate. In treating *ngoma*, indigenous knowledge holders will smear a mixture of herbs and animal fat on the fontanelle to cure the neonate. This practice was also found in the study conducted by Nethra and Udgiri (2018) in India. That study found that 89% of the mothers applied oil to the baby's anterior fontanelle to expedite its fusion.

Prevention of colic (*tshilala*)

Tshilala (neonatal reflux accompanied by abdominal cramps) or colic is an ailment of concern to VhaVenḓa females. In most societies, colic is viewed as a problematic condition that needs attention. The latter statement is supported

by a Jordanian study, which revealed that a solution of boiled herbs or sweetened water is fed to neonates to facilitate sleep by relieving abdominal pain and colic (Mrayan et al. 2018). *Ntswu* is a mixture of boiled water and indigenous herbs used to treat *tshilala.*

☐ Implications of treatment modalities on neonatal health

Traditional birth attendants, elderly family members and mothers might not be aware of the dangers that might be caused by some of the treatment modalities they practice. Installation of herbal juices and palm kernel oil in the eyes is dangerous as these might cause irritation and serious damage to the eyes, which may negatively affect vision (John et al. 2015). Some native chalks are believed to be having antidiarrhoeal action as they contain lead and arsenic substances, and these are poisonous for human consumption (John et al. 2015).

Convulsions are mostly caused by fever; instead of managing convulsions, 'foot roasting' further raises the body temperature resulting in aggravation of the condition (John et al. 2015; Opara et al. 2012).

The smoke inhalation of baboon dung and skin has the potential to cause respiratory problems for the neonate. Equally, the practice of throwing the neonate on the rooftop of a hut could be harmful should the neonate hit hard on the roof or fall while rolling down (Tulelo 2021).

The practice of using breast milk is not harmful. Some clinical studies found that breastmilk, especially colostrum, contains leukocytes and various kinds of immunoglobulins that are effective in inhibiting the growth of *N. gonorrhoeae* and *Staphylococcus aureus*, which are among the main causal organisms of ophthalmia neonatorum in developing economies (Ghaemi et al. 2014). Meanwhile, a University of California (San Francisco) study on the antibacterial impact of breast milk on common paediatric conjunctivitis causes proved that human milk consistently inhibited the growth of *N. gonorrhoea* (Baynham et al. 2013). Therefore, the use of breastmilk for the prevention or treatment of minor infections should be endorsed to accommodate some of the safe practices regarding indigenous neonatal care.

The practice of putting substances on the fontanelle is viewed as unsafe as it can lead to delay in seeking medical intervention for a neonate suffering from dehydration. In this regard, community members need empowerment regarding the importance of immediately seeking medical assistance.

☐ Implications for health care practitioners

Knowledge and understanding of indigenous neonatal care practices by health care professionals might create awareness of such practices in the

communities they serve. This might enable the health care professional to provide support, learn and respect the beliefs and practices that do not pose threats to neonatal health and help in the empowerment of the community members regarding those practices that are harmful.

Collaboration between health care professionals and traditional birth attendants is necessary for the promotion of quality neonatal care. This will enable both parties to work harmoniously as a team, learning from and advising each other regarding safe neonatal practices as well as identification of harmful practices.

Recommendations

Effective collaboration between health care professionals and traditional birth attendants is, therefore, necessary to prevent harmful traditional practices that may negatively affect neonatal health. Rooming-in, which is necessary for the maintenance of the baby's warmth, should be preceded by immediate drying and wrapping of the baby to prevent hypothermia. Otherwise, the practice will not bear results as the damage would have been done by exposure to cold immediately after birth.

Rooming-in should benefit both the mother and the neonate. Though the mother needs to rest, it is of vital importance that the mother spend time holding and cuddling the newborn, looking into its eyes and speaking to the newborn to establish and maintain bonding.

Empowerment of community members regarding the importance and benefits of colostrum, exclusive breastfeeding for the first six months, the dangers of the introduction of solids to newborn babies as well as the dangers of giving herbal concoctions should be given due importance.

Health care education must be imparted to mothers and the elderly members of the communities so that they may understand the physiology around vernix. The fact that newborn babies are delicate and unable to generate heat puts them at a very high risk of hypothermia.

The empowerment of the community members might enable them to understand why bathing should be delayed after delivery. The empowerment of traditional birth attendants and family members regarding the dangers of applying substances on the umbilical cord is important as this might predispose the baby to serious infections such as neonatal tetanus.

Health care professionals working with mothers and infants in the communities should evaluate the traditional neonatal practices in the societies where they work and put interventions in place to correct negative behaviours while encouraging beneficial practices.

Conclusion

Indigenous beliefs, practices and treatment modalities exist in sub-Saharan and other African countries. While some of these have positive implications for the promotion of neonatal health and child development, others may pose threats to neonatal health. Practices that have positive outcomes should be supported and encouraged. However, there is a need to provide culturally relevant and culturally-sensitive health care education on those practices that may pose threats to neonatal health and child development.

Glossary

- ***luselo*:** Large indigenous tray made from reeds.
- ***mirunzi ya vhathu*:** Evil spirits carried by people.
- ***mithuso*:** Ritual performed to protect the neonate from natural and unnatural illnesses, as well as from environmental and external harm.
- ***ngoma*:** Anterior fontanelle.
- ***ntswu*:** Mixture of boiled water and indigenous herbs that are used to treat *tshilala.*
- ***tshidongo*:** An eating or feeding bowl.
- ***tshilala*:** Neonatal reflux accompanied by abdominal cramps or colic.
- ***tshiunza/khongodoli*:** A very light and warm soft porridge with herbal concoctions.
- ***u kanda nwana*:** Transmission of infection or bad spirits to the neonate making it to be sick and putting its life at risk.
- ***zwi a ila*:** Things that are not supposed to be done; when done, result in curses.

Chapter 8

Indigenous knowledge, beliefs, practices and treatments of menopause among females of African descent

Melitah M. Rasweswe
Department of Nursing,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa

Fhumulani M. Mulaudzi
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Abstract

Menopause is also known as *bofelo bja lehlapo or kgwedi* in Sepedi or *ukuyeka ukuya exesheni* isiXhosa or *u sema vhakegulu* in Tshivenḓa and is a normal and natural critical phase of transition for all ageing females. At some point in life and age, each female enters the stage of menopause. Indigenous knowledge on menopause is generated and regulated through views, expectations, understandings and executions that notify this phase. These views,

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expectations, understandings and executions are unique to a group of people living together. They are mainly extracted from the proficiency of ancient knowledge and are passed from generation to generation. If not documented, this knowledge will be lost and that will be a loss to the health care systems.

Various factors, including socio-cultural beliefs and practices such as language, are used to understand the meaning of menopause, attitudes towards menopause, use of taboos, idioms, moral folktales and proverbs, cultural lifestyles such as diet or food practices, individual female responsibilities and physical activities to reduce symptoms and herbal plants and medicines are used as treatment and these influence and affect how an individual female experiences menopausal transition. In African cultures, menopause appears to be understood and treated differently across sub-cultural groups. This chapter outlines various indigenous knowledge understandings of menopause, intending to provide insight into cultural beliefs, practices and treatments for menopause among indigenous females. Understanding this crucial stage of life from indigenous worldviews may assist health care practitioners in aiding patients who seek menopausal health care and offer them culturally safe and acceptable treatment methods. This will improve the quality of care that the clients receive from health care practitioners.

Menopause

The menopausal transition is an unavoidable phase in the reproductive being of each female, which may be influenced by a range of psychological, social and cultural factors. Oloyede and Obajimi (2018) reveal that some females do not notice the transition, while others find it life-changing. Differences in transition among females are suggested to be mostly from the socio-cultural background. While Jack-Ide, Emelifeonwu and Adika (2014) argue that the menopausal transition is personal and depends on the specific anatomical build-up of a person, earlier interpretation, viewpoint and meaning. In the study conducted in South Africa, on understanding perceptions of African females regarding menopause, geographical location supported by cultural beliefs and practices was found to be affecting the meanings and attitudes of menopause profoundly (Rikhotso, Makuwa & Mulaudzi 2015). Furthermore, the participating females expressed the need for a contextual health care support system. It should be considered that as menopause differs from region to region, there will be many ways of managing and treating menopausal symptoms. Most of these in the African context include the use of taboos, idioms, moral folktales and proverbs aligned to the preventive and promotive measures of the illnesses. Cultural lifestyles such as diet or food practices, responsibilities and physical activities are also used to reduce symptoms. Herbal plants and medicines used to prevent and treat symptoms are also available, as opposed to searching for aid from biomedicine therapy such as hormonal replacement.

There is evidence that African people have their cultural norms, values and social systems that form an integral part of indigenous knowledge, including health care beliefs and practices (Idang 2015). This, in turn, influences the understanding and meaning that positively enhances the development of indigenous knowledge in treating illnesses and improving the health care outcomes of the clients. However, this knowledge is often not documented but passed on by word of mouth and becomes a part of the people's lifestyle and is used to seek health care services. Indigenous people are entrusted to maintain these beliefs and practices. The global report on traditional and complementary medicine emphasises the fact that socio-cultural beliefs and practices should be recognised and reflected globally to meet the primary health care needs of the people (World Health Organization [WHO] 2019). This forms an important link between sustainable development and indigenous knowledge, which includes traditional medicine use. Indigenous practices and beliefs influence and underpin the behaviour of females during the menopausal transition. It is, therefore, vital to include cultural beliefs and practices in the management of menopause for African females because it is part of their primary and family health care.

The menopausal beliefs and practices knowledge is generated from different internal and external forces. It should be noted that despite the differences in various African cultures on menopause, as indicated by Ramakuela et al. (2014), there are some common factors in their menopause beliefs and practices that distinguish them from other nations in the world (Anolue et al. 2012; Bello & Daramola 2016; Nkwo 2009; Oloyede & Obajimi 2018). The South African cultural practices, for instance, are more similar to Nigerian practices in the treatment of menopause (Olarinoye et al. 2019; Ramakuela et al. 2014). It should also be noted that the differences may occur because menopause is a difficult transition period with many physical and psychological symptoms such as hot flushes [*fufulelwa*], night sweats, sleep disturbances, loss of energy, urinary frequency, vaginal dryness, poor memory [*go lebala*], irritability, anxiety, mood swings and depression (Ama & Ngome 2013; Oloyede & Obajimi 2018; Yisma et al. 2017). The understanding of the symptoms may be influenced by the understanding of the languages used in making meaning of menopause. In some females, these symptoms can be affected by medical and socio-economic determinants of health, such as underlying health problems (Namazi, Sadeghi & Moghadam 2019). The noted symptoms can affect females' quality of life and attitudes towards menopause.

It is, therefore, important for health care practitioners to be aware of how indigenous people understand menopause. They also need to be updated on how the influences of menopause, socio-cultural beliefs, practices, language, taboos, idiomatic expressions, moral folktales, proverbs, lifestyles and herbal medicines can provide menopausal females with information to make informed choices during the transition. The efforts are directed towards the official

recognition of indigenous knowledge of menopause. Health care practitioners need to know these beliefs, practices and treatments so that they can effectively prevent and manage health care problems that might emerge among indigenous females during the menopause transition. These will also assist in planning and executing health care education, support and counselling for menopausal females based on the local understanding of the meaning and specific practices. The local understanding of menopause must be applied in daily interventions related to menopausal females so that they can cope with the menopausal transition and improve their quality of life. Although the beliefs and practices are African, they are important to be considered internationally for health care innovation and adapted to meet the primary health care needs during the menopausal transition.

Indigenous understanding of menopause

Drawing from the searched African literature, there is no uniform word for menopause. Africans use a common phrase that, if translated, means 'time when menstrual periods stop' or 'cessation of reproductive age'. It was also discovered that language, words, terms and phrases used to refer to menopause relate to menarche, menstruation, reproductive age and end of reproductive age in females (Ramakuela, Khoza & Akinsola 2012; Rikhotso et al. 2015). This might speak to a holistic concept of 'menopause' in which discussion of menopause incorporates the beginning of the female's life journey rather than classifying menopause into pre-, intra- and post-.

Languages reflect a people's worldview in which they make sense of the forces around them (Mokuoane 2018). Various phrases and terms have been used for menopause in different languages, such as *bofelo bja lehlapo* or *kgwedi* in Sepedi, *Ukuyeka ukuya exesheni* in isiXhosa and *U sema vhakegulu* in Tshivenḓa. These terms signify the process of menstrual and reproductive cessation. The understanding of menopause in these South African languages points out the actions or occurrences of events viewed and experienced during the menopausal transition. Many indigenous languages are used to understand menopause. The very same languages influence things that a society chooses to name and reveal the nature of its engagement with the world around it and transmits the meaning (Nkuna 2010). Using the language preferred by an individual female to communicate menopausal issues can help demonstrate an understanding of the meaning of menopause and reflect the perception and attitudes that females may show when seeking health care. The use of phrases and terms known to the females in their respective cultures implies that health care professionals should be aware, understand and not undermine the cultural meanings. This resonates well with the claims made by the National Association of Schoolmasters Union of Females Teachers (NASUWT) teachers union (2021) that differences in language or acculturation in different settings influence the understanding, beliefs and practices.

Knowledge and meaning of menopause vary greatly across cultures. How a society views menopause is influenced by different factors that hold exceptional and memorable meaning to the notion. For example, the findings of the study conducted in the rural villages of Limpopo province, South Africa on the perceptions of menopause and ageing revealed that menopause is a social challenge. Society perceives menopausal females to be getting old, increasingly becoming less attractive and losing beauty (Ramakuela et al. 2014). While in Nigeria, it is viewed as relief from menses and eliminating the risk of pregnancy (Bello & Daramola 2016). Africans might refuse to accept the term menopause if their languages are not considered to reflect some of menopause's characteristics and meanings. Therefore, the meaning of menopause may conflict with other parts of life in different contexts, but what remains in the meaning makes it easy to understand and cope with the symptoms. For example, in many African cultures, menopause is not viewed as a disease but a rite of passage. Central to this understanding is the individual female's menopausal symptoms, beliefs, experiences and practices, the health care-seeking behaviour and care provided by the health care providers such as nurses.

In other cultures, females who have reached menopause are viewed as the elderly (*vhakegulu*) in Tshivenḓa. The status of the elderly *vhakegulu* signifies wisdom and power in the family and community. They are treated with deference, and they are expected to mentor the young regarding traditions and customs in the family and society at large. The elderly females are also viewed as people who qualify to talk to their ancestors as they are considered clean as they are no longer menstruating. Hence, nurses and other health care practitioners need to draw and plan menopausal care from societal perspectives.

Taboos, idiomatic expressions, fables, folktales and proverbs used to prevent complications during menopause

Taboos, idioms, folktales and proverbs incorporate cultural beliefs and values for many important aspects of life for African people (Dundes 1969). Taboos, idioms, moral folktales and proverbs are wise expressions consisting of cultural narratives that are shared among people of a particular group and are believed to play a fundamental role in communicating dos and don'ts. Although taboos are social or religious interdiction, forbidding a particular practice or association with a particular person, place, or thing, they play a significant role in sharing information on societal values, norms, morals, customs, ideas and folkways of managing life (Amali 2014). However, at times this can lead to an incorrect or faulty understanding of the information because of its vagueness. For a menopausal female, many taboos, idioms, moral folktales and proverbs

originate in the mystery that surrounds her anatomical makeup, including her hidden reproductive system, to understand the effects of menopause. The information can also be transmitted through the use of deterrence or inculcating fear to force people to incorporate proper habits and practices for the benefit of the community at large.

Certain taboos are observed by Africans during menopause. Among others, sexual activities are forbidden to protect menopausal females from developing illnesses and complications. Most of these taboos and proverbs are usually used in deterrence or to inculcate fear. For example, in Zimbabwe and Mozambique, it is taboo for older females to engage in sex (Moyo 2016). In South Africa and southeast Nigeria, females do not continue to engage in sex during menopause because it is said that they will develop abdominal problems and illnesses that will not be diagnosed and treated (Ibraheem, Oyewole & Olaseha 2015). Kyomo and Selvan (2004) add that in Nairobi, Kenya, people believe that a menopausal female who is still having sexual activities will be noticed by a bulging stomach growing very big because of the sperms that accumulate and are not cleansed away monthly. They also believe that the accumulated sperms will produce a stinking seminal fluid through the vagina, making it difficult for such females to go to public places. Baloyi (2013) indicated that Vatsonga refer to a bulging stomach as *xikuru-nyimba*, while the VhaVenḓa call it *tshikwilimimba*. The above-mentioned beliefs make menopausal females afraid of engaging in sexual intercourse as they do not want to risk their health and be embarrassed by the illnesses of engaging in sexual activities.

Among Shangaans or Vatsonga there is a strong belief that it is unsafe for a male to have sexual intercourse with a female in menopause. It is believed that menopausal females must be sexless as they are no longer capable of producing children. Menopausal females who engage in sex are considered 'dirty' and they may infect males with sexually transmitted infections (STIs) (Mulaudzi 2007). It is also believed that the blood that used to come out of the female's body during menstruation no longer comes during menopause and will enter the male during sexual intercourse. If that happens, the testicles of the male will swell until they die (Moyo 2016). The illness is referred to as *mokabe* in Sepedi (see ch. 9) and is compared to hydrocele in western medicine. As such, Vatsonga males fear illness and death and do not indulge in sexual intercourse with females who have reached menopause.

Menopausal females are also encouraged to abstain from sexual activities to avoid hip dislocation because their bones are weak. Ibraheem et al. (2015) highlight that traditionally, Nigerian females abstain from sexual intercourse immediately after menopause because they believe that monthly bleeding washes away impurities in the female's womb, and the impurities accumulate in the absence of menstrual flow. Therefore, if she engages in sexual activity during her menopausal transition, she will get sick because of impurities.

In Zimbabwe, the Karanga Mberengwa people and the Shangaan of Mozambique females who reach menopause are barred from having sexual intercourse to prevent any complications that might occur (Moyo 2016). The study conducted in Uganda reports that it is an abomination for menopausal females to participate in sexual activity; however, it is acceptable for males (Okira 2014). While African menopausal females observe the taboo of sexual activity, their husbands are also prohibited from engaging with them in this act.

Males's involvement improves coping techniques, particularly the husbands supporting their wives during menopause, as noted among the Yoruba people in Nigeria. Males abstain to protect their wives. However, some females reported that the practice promotes immorality and promiscuity among males (Agunbiade & Gilbert 2019). At times this happens openly with the husband marrying a younger wife, with the intention of relieving the menopausal wife from having sex to honour cultural beliefs as it is labelled cultural and males themselves are still sexually active. This practice is also common among the Karanga people of Zimbabwe and Shangaan communities in Mozambique (Moyo 2016).

In Africa, the menopausal process is kept secret and preserved until the ageing is obvious. Despite the joy that menopause can bring to certain females, it is not allowed to share their experiences with others except close family members. According to some elderly females, it is done to protect the female from being labelled as old and unproductive. These views have valuable implications for collaboration in the co-creation of menopause public education, social interventions, policies and the collective personal responsibility of health care-promotion practices that focus on the safe menopausal transition.

Rites and ceremonies

The life passage of African people is usually celebrated through rites and ceremonies. Menopause (cessation of menstruation), just like menarche (beginning of menstruation), is celebrated by some African people. In some African communities, rituals are performed to protect females from menopausal challenges, such as temptations to engage in sexual activities. For example, the Karanga in Zimbabwe perform a ritual called *kugura nhowo* (cutting of the reed mat) (Moyo 2016). This ritual is performed as a ceremony of separating a couple from sharing a bed or having sexual intercourse after the female reaches menopause. This ritual is designed to sanctify the female's reproductive organs change brought about by menopause and reverse the sexual role that was celebrated during menarche. It shows that indigenous people understand females' biological setup and changes. For example, it is known in western medicine that as females age, the body produces less estrogen, which is needed to keep the vagina moist and supple

(Freedman 2002). The vaginal walls also become thinner and weaker. In their understanding, if a female continues to have sexual intercourse, she can experience pain. Only older females and males attend this ritual. The cutting of the sleeping mat means that each partner can sleep on their bed, even though they are sharing the same room. In South Africa, racial groups such as the AmaXhosa follow the same practice. Although there are no ceremonial practices, one of them will leave the main bedroom. Usually, a female will use her room but continue taking care of the husband, fulfilling other wifely expectations and activities (knowledge shared by an elderly isiXhosa female). In this regard, according to the VhaVenḓa, Bapedi and AmaZulu if the husband is still sexually active, the wife can bring her young sister or the daughter of her brother as a wife to her husband.

Among the Batlokwa, menopause is marked by the females who are willing to join a group of elderly females, to which a new name is given. The naming is called *leina la bokgekelo*, whereby from the day of marking onwards, that female will be called by that name. The naming is celebrated with music and dance. A menopausal female joins females' gatherings to keep busy and share menopausal experiences with other females. These, therefore, call for cultural awareness and acknowledgement of indigenous menopausal knowledge beneficial to the well-being of menopausal females.

Although there are limited rites of passage to celebrate menopausal transition in most African communities, Ramakuela et al. (2014) reveal that the information is communicated indirectly during other rites, rituals and ceremonies through moral folktales so that they can assist further in understanding beliefs and practices of menopause. These practices affirm that menopause is not an illness but a natural part of life and should be celebrated.

Attitudes towards menopause

While menopause is a biological process, in Africa, the process of transition is embedded and observed from the societal, cultural norms and values. Females from all over Africa have different attitudes and expectations about menopause. In Zimbabwe, menopause is viewed as not distressing but as a natural part of the life cycle (McMaster, Pitts & Poyah 1997). Rikhotso et al. (2015) argue that this multitude of attitudes should be considered for better treatment of menopausal females because they play a major role in the way an individual female perceives menopause. Hofnie-Hoebes et al. (2018) allude that these attitudes can be positive or negative for menopausal females.

Positive attitudes

Positive attitudes come from better societal positions awarded to menopausal females by the community. Wambua (1997) alludes that in some cultures, menopausal females are awarded equal status with males. In addition,

community members value their existence and look up to their wisdom. In general, post-menopausal females are usually more comfortable and positive with this change. They also accept the process as a natural process of ageing and life changes (Ande et al. 2011). Ande et al. (2011) indicate that some enjoy the transition to the post-reproductive life stage because there is no childbearing and child-rearing. In some communities, menopausal females are honoured and regarded as wise because they completed their fertile phase of womanhood. This can be seen more in societies where menstruation is regarded as impure; thus, cessation of menstruation grants females better status within the community and release from menstrual problems such as heavy bleeding, dysmenorrhoea, premenstrual syndrome (PMS), etc. The females from these societies report lower symptoms because of positive role changes. Some positive attitudes are identified in females who associate menopause with relief from menstruation (Adekunle, Fawole & Okunlola 2000). This is mostly noted in females who have had multiple births because it signifies an end to childbearing without the use of control methods (Ande et al. 2011).

Negative attitudes

Negative attitudes may arise from the negative experiences and ideas identified before reaching menopause and influence the possibility of encountering inner and physical manifestations. Females who dismiss menopause and ageing usually have unfavourable menopausal signs and experiences. Premenopausal females usually portray negative connotations such as menopause causes illnesses; most African females associate menopause with a death sentence because of the health care challenges they have heard about. They, therefore, fear having menopausal symptoms. The Batlokwa females refer to menstruation as *lethlapo la popelo* cleansing of the uterus; however, with some females, the cessation of menstruation can be related to illness because the uterus is no longer cleansing itself. A similar notion has been reported in Ibadan, southeast of Nigeria by Ibraheem et al. (2015). The loss of womanhood – when females reach middle-age, they are less attractive because they lose their youthful attributes. They also associate menopause with ageing – the entry point to old age is a challenge to African females because society perceives them as not fully functional. When females transit to menopause, still feeling young and energetic, and society on the other hand, sees them as old and useless, females might have negative attitudes towards menopause. In support, Ramakuela et al. (2014) indicate that this is because in rural villages, people discredit ageing and have a negative attitude towards elderly females. This often results in stereotyping and labelling them as *gegulu* (elderly/senior female) despite gaining respect for entering this stage. It can be argued that if females are valued based only on their physical and sexual makeup, they might experience menopause negatively because their physical and sexual attractiveness diminishes.

In addition, females who value fertility as a high priority tend to have more negative attitudes toward menopause (Ande et al. 2011). This manifests when a female reaches menopause childless or before achieving the number of children desired (Wambua 1997). Therefore, menopausal symptoms could be the beginning of depression for such females. This is seen in many African countries. Negative attitude toward menopause arises from a lack of knowledge and support from others, stigma and discrimination. For example, in a Nigerian survey, 70% of females were troubled by menopause and ageing, thinking that they were giving up their muliebrity and fearing losing their husbands to younger females (Ozumba et al. 2004).

Psychological and socio-cultural factors are also contribute to varying females' menopausal experiences. Psychologically, the attitudes that individual females have towards menopause are unique and play a significant role in how they react to the menopausal transition. However, socio-culturally, females in various countries attach contrasting nuances and definitions to understand menopause. These are influenced by the social and cultural thoughts, belief systems, practices, social suggestions and support systems available within the context in which a female lives (Ama & Ngome 2013).

Paying attention to many nations in Africa, there are discrepancies seen in disclosing the signs and manifestations of menopause. The discrepancies can be connected to language and are associated with the way society views menopause. The taboos, idioms, moral folktales, proverbs and metaphors used are dominated by negative terms, words and phrases such as *mmereko wa gago wa bosadi o fedile*, meaning that your muliebrity came to an end. This implies that, as a female, you should bear children, and the moment you reach menopause, you are no longer seen as a complete (childbearing) female.

Lifestyle beliefs and practices in reducing and managing symptoms of menopause

Dietary practices/food consumed

Diet or food habits and cultural context play an important role in every female. Africans use diet or food to modify the underlying challenges that occur during the menopausal transition. Africans prefer home-cooked meals. A female who is undergoing the process of menopause is expected to follow a rich and nutritious diet to remain healthy in her old age (Ramakuela 2020). To maintain energy, they eat a large portion of healthy foods at breakfast and supper. Lunch is usually supplemented with seasonal fruits available in their area or dried fruits preserved from their fruit trees. Typically, meals are made using sorghum bicolor to make *mabele*, as well as soy products like cowpeas or *dinawa*, scientifically known as *Vigna unguiculata*, a protein-rich legume, and lots of fresh vegetables and dried vegetables, such as the leaves of the

cowpea legume plant called *morogo wa dinawa*, which are rich in proteins, fibre, iron, calcium, phosphorus and zinc (Van Jaarsveld et al. 2014). *Morogo* is the Sepedi word referring to green or dried leafy vegetables, while *dinawa* means beans. The preferred maize meal used is usually from sorghum grain *mabele*, which is believed to reduce the chances of developing cancer. Chen, Lin and Liu (2015) argue that *mabele*, soy and vegetables are antioxidants, therefore regulating body weight and ensuring a lean body mass, which can be beneficial to menopausal females. Nahas et al. (2004) add that soy products exert favourable effects on vasomotor symptoms that most menopausal females experience, and it is good for maintaining the strength of the bones. Bosman et al. (2008) recommend soy products to be included in the daily diet or food of menopausal females because soybean is rich in phytoestrogens, which are believed to alleviate excessive body heat, sweating and some of the symptoms caused by menopause transition.

The variety of seasonal green vegetables or African spinach known as *morogo* in Sepedi, *murohu* in Tshivenḓa and *imfino* in isiXhosa is commonly prepared and consumed. For example, okra or *nkuruma* in Twi language, scientifically known as *Abelmoschus esculentus*; a variety of wild or cultivated spinach; pumpkin leaves and flowers or *boloba*, bean leaves, and any other edible leafy vegetables known are consumed. Okra has many health benefits. Okra fruits and leaves are considered vegetables and can be eaten fresh or dry, raw or cooked. Okra is identified by numerous names known locally by regions of the world. It is called *kenkase* in Ethiopia, thelele in Sepedi, delele in Tshivenḓa and gushe in Xitsonga. It is favoured in South Africa, Botswana, West Africa and Ethiopia as it is rich in magnesium, iron, antioxidants, vitamin C, vitamin K1 and vitamin A and controls heart conditions and blood sugar levels (Avallonea et al. 2008; Sathish & Eswar 2013; Van Rensburg et al. 2007). In the review of the nutritional quality and health benefits of okra, Gemede et al. (2014) discovered that its various nutrients, multivitamins, minerals and electrolytes nourishes the body. Therefore, consuming okra can be more nutritional and holds numerous health benefits for menopausal females.

Meat is usually substituted with edible insects such as locusts, *Gonimbrasia belina*, commonly known as *mopani* worms (*mashonzha*), which are rich in protein, iron and zinc and found in the warmer parts of southern Africa. All these are beneficial to menopausal females. Apart from their nutritional value, edible insects are inexpensive and easy to harvest.

Menopausal females in Africa are also expected to include lots of water in their diet and refrain from consuming certain types of food. Food that is fatty and unhealthy is discouraged because it is associated with illnesses that occur during this period, such as high blood pressure or *tshikelelo lowukulu* in Xitsonga and *madi a magolo* in Sepedi, or diabetes mellitus or *chukela* in Xitsonga, and heart diseases. The study conducted in a rural part of the Limpopo province, South Africa, confirmed that menopausal females reduce their intake of foods

which are high in sugar and salt (Ramakuela 2020). Therefore, different types of African food should be considered to reduce varying symptoms of menopause to help females get through the menopausal phase more easily. For more information on the benefits of the above-mentioned food, refer to the chapter on indigenous food.

Physical activities

Another lifestyle practice found to be important and beneficial to health care during menopause among African indigenous females is physical activity. According to WHO (2020), physical activity is associated with many health benefits, such as reducing the risk of heart illnesses, mental health, cancer and being overweight. The evidence points out that continuous physical movement and exercise improve the symptoms associated with menopause (Li et al. 1999). For African females, physical activities have been part and parcel of their lives during the menopausal period. The menopausal females in rural areas usually spend time working in their gardens, walking instead of using transport and doing household chores. They also freely attend and participate in ceremonies, be it joyous or sad; they dance and sing because indigenous African people use sound, melody and dance for comfort or to show happiness. These practices relieve loneliness and stiff joints, as well as prevent stress and irritability related to menopause because singing and dancing involve exerting energy and emotional attachments. In Nigeria, it was observed that there is a clinical significance of lowered blood pressure in menopausal females who are involved in rigorous physical activities (Ogwumike et al. 2014). Therefore, indigenous exercises such as walking, dancing and household activities are recommended for menopausal females as a means of alleviating some of the signs and manifestations linked to menopause.

Indigenous treatment of menopause

Menopause is natural in the ageing process, and many symptoms dissolve over time. However, in some females, it causes problems and challenges that can be relieved by treatment and management of symptoms. The literature reflects the popular use of herbal plants and medicine by Africans, which aim to treat, protect, prevent and promote coping techniques. According to Setswe (1999), indigenous health care and healing refer to the ancient system of understanding, managing and treating illnesses, either with herbs or any other methods believed to be effective, which are culturally orientated and used before the discovery of Western healing practices.

Herbal plants and medicines used by females in different communities for the treatment of menopause, such as *Actaea racemosa*, known as 'black cohosh', are recorded and registered mainly in ethnobotanical studies (Moteetee & Van Wyk 2006; Semenya et al. 2013). Black cohosh carries phytoestrogens, specifically flavones that assist in enhancing the production of the oestrogen hormones. The

high production of oestrogens is needed to control and adjust the body temperature, which in turn reduces the symptoms, such as hot flashes and night sweats (also known as nocturnal hyperhidrosis). A comparative study conducted in 2018 revealed that black cohosh and evening primrose oil (Oenothera biennis) are successful in reducing the severity and danger of hot flashes; however, black cohosh is seen to be more effective than evening primrose oil (Mehrpooya et al. 2018). Apart from relieving hot flashes and night sweats, a study conducted by Shahnazi et al. (2013) among postmenopausal females confirmed that black cohosh is effective in the lubrication of the vagina, a reduction of palpitations, anxiety and depression, and strengthening bones.

The other common herb used by South African females to relieve hot flashes or *fufulelwa* (in Sesotho) is *moqopolla-thula*, also known as red clover (Moteetee et al. 2016, p. 35). The users also indicated that it fights osteoporosis. African females also consume *theepe* (young pigweed shoots) as a vegetable or drink the water after boiling it. These edible herbs are mainly found in the local areas where most nations reside. This is expressed by Semenya et al. (2013), who note that ancient herbs and plants are still spotted in the Bapedi communities and are utilised for their holistic nature. Because the use of these herbs and plants is proven to be of good use in treating females in menopausal transition, it should be used openly and widely. See Table 8.1 for herbal medicine used to treat menopause.

TABLE 8.1: Herbal medicine used to treat menopause.

Name	Scientific name	Country of origin	Benefits	Form of consumption
Kanna or *kougoed* [something to chew]	*Sceletium tortuosum*	South Africa	Used to enhance mood swings, irritability, stress and depression experienced in menopause. Improves libido	Chew, sniff or smoke powder, taken in a form of tea
Black cohosh	*Actaea racemose*	Eastern North America	Controls hot flashes, vaginal dryness and excessive sweating and it is a mood enhancer	Ground powder, liquid mixture, or an extract
Lelothoane [sage wood leaves]	*Buddleja salviifolia*	South Africa	Sage has been a well-known hot flash remedy for many years. The reason it works so well is that it contains flavonoids, volatile oils and tannins	Wet or dried leaves
Moqopolla-thupa [Cape clover red]	*Trifolium Africanum*	South Africa	helps relieve hot flashes	
Mphephi or *motlhatlhaila* [old female's bush]	*Rehmanniana* (Pestal)	South Africa	Helps to relax	Leaves
Theepe [pigweed/ young shoots]	*Amaranthus cruentus* or *palmeri*	South Africa	Provides organic minerals	Leaves

Source: Adapted from Moteetee and Van Wyk (2006) and Semenya et al. (2013).

Recommendations

The chapter recommends the recognition of local indigenous knowledge related to menopause by all health care practitioners and the public at large. The recognition will lead to the use of menopausal beliefs and practices without fear of being labelled as wrong. Any harms or dangers that are identified should be modified to still suit the use of the knowledge. It is also important to teach females about menopause from puberty at the girls' initiation schools, academic schools and females' gatherings so that females should be able to know, understand and deal with the symptoms of menopause when they reach the stage and experience the symptoms.

Conclusion

This chapter addressed indigenous knowledge, beliefs, practices and treatments related to menopause *bofelo bja lehlapo* or *kgwedi*. It also outlined how African indigenous females understand menopause, the language used to refer to menopause, taboos, idioms, moral folktales and proverbs used to prevent complications during menopause, rites and ceremonies, attitudes towards menopause, lifestyle beliefs and practices in reducing and managing symptoms of menopause and indigenous treatment of menopause. The argument presented is that Africa has its effective ways of dealing with menopause and their ways are used successfully and can co-exist with others rather than be viewed as inferior and overlooked.

Drawing from beliefs and practices, it is evident that menopause in Africa is based on different aspects, such as cultural understanding of human existential behaviour, language, norms and values. This gives rise to the continuous learning of indigenous menopause knowledge and learning about menopause should always consider the culture and local language. This is an opportunity to help females build a more concrete understanding of their bodies during this transitional phase of life and think about how to manage the process concerning their own beliefs and practices. It is therefore important to preserve this information through documentation.

Glossary

- ***bofelo bja lehlapo or kgwedi/ukuyeka ukuya exesheni/u sema vhakegulu*:** Menopause
- ***chukela*:** Diabetes mellitus
- ***fufulelwa*:** Hot flashes
- ***gegulu*:** Elderly/senior female
- **isiXhosa:** Part of the branch of Nguni languages known as Zunda languages, which include isiZulu and isiNdebele. IsiXhosa is mostly spoken in the Eastern Cape and Western Cape provinces of South Africa.

- ***isiZulu*:** A Nguni branch-language spoken in southern Africa. Speakers primarily live in the KwaZulu-Natal province of South Africa.
- ***kanna/kougoed*:** Something to chew
- ***kugura nhowo*:** Cutting of the reed mat
- ***leina la bokgekelo*:** Old-age name.
- ***lelothoane*:** Sage wood leaves
- ***lethlapo la popelo*:** Cleansing of the uterus
- ***madi a magolo*:** High blood pressure
- ***mashontsa*:** Mopani worms
- ***mmereko wa gago wa bosadi o fedile*:** Womanhood came to an end.
- ***moqopolla-thupa*:** Cape clover red.
- ***mphephi/motlhatlhaila*:** Old female's bush
- ***n'ombe*:** High blood pressure in Xitsonga.
- ***Sepedi*:** Language spoken by a subgroup of the Sotho people living in the Northern parts (Limpopo province) of South Africa.
- ***theepe*:** Pigweed/young shoots
- ***VaTsonga*:** Mostly found living in the Limpopo and Mpumalanga provinces in South Africa, as well as in Mozambique.
- ***VhaVenḓa*:** South African people mostly found living in the Limpopo province, near the Zimbabwean border.
- ***xikuru-nyimba*:** Bulging stomach
- ***Xitsonga*:** Tsonga/Shangaan

Chapter 9

Sexually transmitted infections: An indigenous African context

Fhumulani M. Mulaudzi
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Melitah M. Rasweswe
Department of Nursing,
Faculty of Health Sciences, University of Limpopo,
Polokwane, South Africa

Abstract

In modern biomedicine, sexually transmitted infections (STIs) are classified according to their causes, treatments and complications. The range of nomenclature associated with these infections is known and accepted globally. However, cultural perceptions and beliefs also influence the understanding of health care in general, as well as STIs in particular, known as *malwadze a vhudzekani* in Tshivenḓa and *malwetši a thobalano* in Sepedi. Several research studies were conducted on the perceptions of community members and indigenous knowledge holders concerning the types of known STIs and the language used to describe them as treated by traditional health care practitioners. However, the indigenous treatment options are still not

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well-documented in Africa. In that regard, this chapter focuses on the documentation of the historical and current background of STIs in Africa in the context of their causes, treatment modalities and plant species used for treatment. The chapter also focuses on methods that can be used to mitigate risks and risky behaviours through preventive and promotive measures that are accessible, culturally safe and acceptable. The chapter concludes with an emphasis on the need for health care professionals to develop their knowledge and understanding of STIs, as well as their naming from an indigenous perspective. It is recommended that the indigenous domain of STIs be included in the health care professionals' curriculum.

Transmission of sexually transmitted infections

According to the World Health Organization (WHO 2019), STIs remain one of the top ten diseases for which many grown-up people in developing nations seek health care. Globally, over 1 million reported cases of STIs occur daily, of which 86 m were recorded in sub-Saharan Africa (WHO 2019). Moreover, STIs are a major cause of high morbidity in South Africa, although they rarely cause death. The transmission of sexual illnesses can occur while the baby is still in utero, causing complications such as miscarriages, stillbirths, infertility and blindness (Maema, Potgieter & Samie 2020). The South African Department of Health (DoH) is responsible for developing guidelines for the management of STIs. Syndromic management of diseases is commonly applied, in terms of which treatment is administered to clients based on the symptoms of the disease; rather than prior confirmation of the type of the bacteria causing the particular disease through laboratory-based tests. The syndromic process makes it impossible for common STIs to be determined. However, common STIs such as *dorobo* [gonorrhoea], *thusula* [syphilis], chlamydia, trichomonas, chancroid, genital herpes, genital warts*, dzinnda kha vhudzimu ha vhasadzi kana ha vhanna* [pubic lice], HIV and AIDS are well-documented in modern biomedicine. In addition, their causes, treatment and prevention mechanisms have also been well-articulated. Contrastingly, some known STIs in the indigenous health care communities are still not well-documented or well-articulated in modern African health care textbooks.

According to the National Institute of Allergy and Infectious Diseases (2019), the term STIs is used in modern medicine to describe syndromic diseases that are transmitted from one person to another through sexual intercourse. However, traditional African health care practitioners describe STIs [*malwadze a vhudzekani*] as infections that are transmitted during sexual intercourse; and those that occur because of the transgression of sexual intercourse restrictions during culturally prescribed days. Cultural perceptions on awareness, knowledge, beliefs and practices regarding STIs are very

important as they affect early diagnosis and treatment uptake of these infections. Although the *Traditional Health Practitioners Act (No. 22 of 2007)* emphasises the inclusion of traditional health care practitioners in the prevention and treatment of diseases, the traditional health care system is still not recognised as the afore-said Act prescribes. Traditional health care practitioners are still overlooked in the prevention and treatment of disease in hospitals and primary health care settings, making it difficult for patients to make autonomous choices of their preferred health care practitioner in respect of the required treatment.

South African research shows that 80% of clients still visit traditional health care practitioners for STI treatment because of affordability and accessibility considerations (Latif 2010). A 2003 KwaZulu-Natal study showed that 365 of the hospitalised STI patients during the previous 12 months were admitted to first consulting a traditional health care practitioner before consultations with a biomedical doctor (Mngqundaniso & Peltzer 2008). The latter state of affairs confirms the assertion by Mufamadi (2009) that clients preferred treatment by traditional health care practitioners as they provided holistic client-centred care. Furthermore, the majority of clients prefer to be treated by traditional health care practitioners in their communities based on the belief that their condition will remain confidential. The hospital environment, on the other hand, is regulated by transparent STI treatment policy guidelines requiring that the infected persons (males or females) should also bring their spouses or partners along to ensure that both are treated. Compliance with such a policy requirement is often difficult because some of the affected are also involved in extramarital relationships. In other situations, females are subjected to violence when requesting their spouses to receive STI treatment at biomedical health care centres.

As early as the 18th century, several researchers in different African countries such as Mozambique, South Africa, Zimbabwe and Zambia conducted research to document unknown STIs (Green & Tuck 1997; Hossan et al. 2010; Mulaudzi & Makhubela-Nkondo 2006; Ndubani & Hoer 1999). Despite these initiatives, the classification of STIs among different African communities has not been incorporated within the health care system yet. The gap between diagnosis and treatment practices is often based on linguistic differences. Commendably, the names of these diseases are similar throughout different African countries. Linguistic and terminological constructions play a significant role in explaining and understanding infections. For example, in some communities, the infection, commonly known as *syphilis* in Western biomedicine, is known among the indigenous communities as *thusula* in Tshivenḓa, or *ingcusula* in isiZulu. Meanwhile, *gonorrhoea* is known as *dorobo* or *itolopo* in isiZulu. In Lozi (western Zambia), STIs are commonly known as *matuku a sihule* or *butuku bwa sihule*, which means 'the diseases of the prostitutes' (Chinsembu 2016). In other South African cultures (e.g. among the VhaVenḓa), STIs were commonly

known as females' infections (*malwadze a vhasadzi*). It was only through gender equality sensitisation that perceptions have changed, and the self-same disease is now being referred to as *malwadze a vhudzekani*, in recognition of the infection as attributable to sexual intercourse.

The indigenous contexts and terminological references to STIs could greatly assist Western biomedical health care practitioners in understanding the diseases more holistically and making them better placed to provide preventive health education and care (Sifunda et al. 2007). Studies conducted with traditional health care practitioners and indigenous community holders also identify other sexually-related conditions or infections that are not profoundly documented and listed in the predominant biomedical literature. These undocumented sexually-related infections include *tshovela* (genital warts), *popelo* (lower uterus abdominal) pain, *ikhubalo* and *uwela* (to fall in) disease (Mulaudzi & Makhubela-Nkondo 2006; Sifunda et al. 2007). Traditional health care practitioners were known to be effective in their treatment of STIs such as *dorobo* (gonorrhoea) and *tshofela*, *thusula* (syphilis) (Mngqundaniso & Peltzer 2008).

This chapter aims to identify and document different types of STIs as understood by traditional health care practitioners, traditional birth attendants and key informants among African communities. This aim is addressed from a dualistic perspective. Firstly, an outline is provided of known STIs among African indigenous communities, but are unknown and undocumented in the predominant Western biomedical literature. Secondly, the commonalities in STI terminological references are also highlighted in respect of both the Western and traditional health care contexts to assist Western biomedical health care practitioners in understanding patients when diagnosing and treating them.

Types of sexually transmitted infections

Sexually transmitted infections can be categorised into two types, the known and the unknown variants in the Western biomedical health care system. The known infections include *dorobo*, *thusula* and *tshovela.* On the other hand, the unknown STDs relate to examples such as *divhu*, *tshimbambaila*, *mafa*, *goni*, *tshipande*, *popelo* pain and *mokabe*, *tshikwilimimba* and *lukuse*.

Infections known by Western medicine

Dorobo/itoropo

Dorobo/itoropo is well-known among many African communities. For example, studies conducted in both South Africa and Mozambique described the infections in similar terms (Mulaudzi 2009). The studies are in concurrence that the signs and symptoms are similar for gonorrhoea. However, African

communities referred to the symptoms to name the infection. *Dorobo* or *itoropo* is transmitted during sexual intercourse. The term *itoropo* is commonly used in informal settlements and emanates from the patios inherent in the language used in mines. As such, the term connotes the dropping discharges reminiscent of the signs and symptoms of the infection.

Screening patients for their medical history and symptoms of the infection remains one of the viable methods used by traditional health care practitioners to assess their clients' STIs diagnostically with the throwing of bones (*thangu/ditaola/ukuhlahluba*). The traditional health care practitioner will enquire about the nature of the clients' complaints, usually reported as a heavy discharge that later becomes yellow in colour, if not treated early. Females experience it differently from males. For example, females may complain of pain in the lower abdomen, which is accompanied by a heavy malodorous discharge and itchiness of the vagina; followed by a burning sensation when they urinate and experiencing pain during sexual intercourse (Mulaudzi & Makhubela-Nkondo 2006). Males, in turn, experience a burning sensation while urinating, a heavy yellow discharge and testicular pain, which they usually discover earlier than females because they naturally do not have a discharge.

Itoropo is a lifestyle infection and is attributed to infidelity. Infections spread from one person to another. Studies show that both males and females prefer traditional healers using herbal medicine for the treatment of STIs. An ethnobotany study conducted by De Wet and Van Vuuren (2012) in northern Maputaland and South Africa revealed the existence of 33 indigenous plants for the treatment of STIs. The roots and bark of those plants are used for herbal medicine, which can be administered orally, or rectally as an enema (see Table 9.1).

If not treated early, the STI may ascend to the pelvic area. In the event that the female is pregnant, the infant may be born with excessive eye discharge and also blindness if the infection is not treated well.

☐ *Tshovela/tshofela*/cauliflower

Tshovela is one of the common STIs cited by traditional health care practitioners in African countries such as Mozambique, Liberia, Zimbabwe and South Africa (Green & Tuck 1997). The infection spreads through oral, vaginal or anal sexual intercourse and is believed to manifest as genital warts in modern biomedicine. Genital warts develop as white sores that grow and cover the genitals as they multiply. These warts look like cabbage or cauliflower (Green & Tuck 1997). The diagnosis differs from one traditional health care practitioner to another. Some diagnose by means of assessment which entails history-taking, observation and examination, while some may diagnose through the throwing of bones (*thangu*) and consulting ancestors (*vhadzimu*) to assist in the diagnosis.

The dominant treatment is through mixed herbs administered orally or as a form of an enema. Topical herbs may also be used.

Thusula/thosola

Thusula is one of the commonly known STIs found even in Swaziland and some of the nearby states and bordering countries. It is called *gcunsula* or *gcushuwa* in other languages. *Thusula* manifests in widespread sores as the sign and symptom of the infection. The description, signs, symptoms and complications of the infection are similar to what is diagnosed as syphilis in modern biomedicine. This infection is transmitted sexually. Dirt is identified as the cause of the disease. Screening and history-taking of the clients are conducted during consultation, followed by observation to confirm the medical history. The symptoms usually lead to the diagnosis of the condition.

Thusula manifests with itchy sores in the genital area. The sores are accumulated with secretions that look like water and are painless at first, but as the infection progresses, pain is reported. Delaying treatment results in the infection spreading to other body parts. The infected person will initially present with blister-like sores. In cases of expectant mothers, they may choose to abort the foetus to avoid having a miscarriage. The treatment is in the form of herbs that are mixed and administered orally (see Table 9.1 for the herbal names of *thusula* treatment). *Thusula* complications are fatal, and pregnant and lactating females need to be treated soon after diagnosis. Lack of proper treatment may cause miscarriages, mental illness and depression, which may slowly manifest in hallucinations. Further complications can also lead to death (Mulaudzi & Makhubela-Nkondo 2006).

Infections that are not known by Western medicine

Divhu/uwela/falling into

Divhu is an STI that mostly affects males involved in sexual intercourse with a female who had an abortion or a miscarriage. It is believed that a female must first visit a traditional health care practitioner for treatment following an abortion or miscarriage. Additional to this form of treatment, the female has to menstruate first before engaging in sexual intercourse. Menstruation is viewed as cleansing from an abortion or a miscarriage. As such, a female who has not menstruated after an abortion is viewed as unclean (infectious). The condition is commonly known as *ligalo* or *lugalo* in Mozambique and *kahungo* in Zambia among the Tonga. Therefore, the causes or predisposing factors of *divhu* are similar in South Africa, Mozambique and Zambia and depict a female who is considered unwholesome because of the abortion (Green & Tuck 1997).

The signs and symptoms of *divhu* vary from one male to another, depending on the individual's immune system. For instance, males who have a weak immune system may succumb to death within three to four days of contracting the infection, whereas those with stronger immunity may recover and survive the infection. Males present symptoms, such as a headache, shivering, dry mouth, fatigue and drastic weight-loss because of the loss in appetite. In acute phases, the male may experience urinary retention, which might develop into dysuria. Furthermore, the bowel may stop functioning. Delayed or lack of proper treatment later causes the teeth to protrude through the mouth, making it difficult for the male to close their mouth. In severe cases, the anterior fontanelle may start pulsating like that of a baby (Mulaudzi 2007).

History-taking and symptom-monitoring often provide clues on the nature of the ailment. Throwing of bones is also used by traditional practitioners to diagnose the infection, which is contracted by a male who had sexual intercourse with a female who had an abortion. The female is said to be 'dirty' and has infectious discharges as they were not cleansed after the abortion. The treatment is often very difficult as both partners are supposed to be treated simultaneously. However, females tend to be untraceable for fear of reprisals and victimisation by their spouses. The herbal treatment used is mixed with the urine from both partners, who then must drink the concoction. There are certain herbs that are used by one partner in cases where it is often difficult to trace the other partner.

☐ The condition *shimbambaila/ikhubalo/likhubalo lenja/ureiwa/runyoka/lunyoka*

Tshimbambaila is described as having sexual intercourse with a female whose vagina is 'locked' or 'fenced'. The condition is related to a jealous partner who wants to prevent their spouse from being infidel or having extramarital affairs. Infidelity has always been a challenge among married couples, but indigenous methods have been used in many parts of Africa to address the situation in terms of how the male 'locks' the female's vagina using *muthi* to prevent her promiscuous conduct. The practice is common in the African continent and is called *ikhubalo* in the Nguni languages, *likhubalo lenja* in Mozambique, *tshimbambaila* in Tshivenḓa and *magun* (thunderbolt) in Yoruba, which means 'do not climb', or 'do not have sexual intercourse with another's wife'. In Zimbabwe, it is called *runyoka/lunyoka*. The male uses medicine mixed with herbs to lock the wife (Shoko 2007). In other cases, the husband gives the wife a knife smeared with medical herbs to close. Unknowingly, closing the knife would be tantamount to locking the wife from any future adulterous practice.

Shoko (2007) mentions *urwembwa/rwebanga* and *rwehove* as two of the well-known types of locking practices in Zimbabwe. In the case of *urwembwa* or *rwebanga*, a male who commits adultery with a locked female will not be able to remove his penis unless a traditional healer intervenes to remove it using some herbal concoctions. Nowadays, biomedical surgical procedures are used in an operating theatre to 'unlock' the situation (Green & Tuck 1997; Mulaudzi & Makhubela-Nkondo 2006). The second type of locking is called *rwehove*, in which case the offending male is given a choice to be partially immersed in water so that they can be forgiven. If they refuse to take the water immersion punishment, they will die.

A study on the ethics of *runyoka* by Dewah and Mutula (2014) revealed that females were unhappy with the practice of *runyoka*, which they considered a violation of the privacy and self-dignity of their spouses. They also argued that *runyoka* prevented divorced females or widows from moving on with their lives and remarrying as they would still be locked. The other painful aspect relates to the death of the husband of a locked wife, as the wife cannot remarry and continue with their life. The practice is frowned upon as promoting domestic abuse and gender inequity.

Traditional treatment options include the use of *kugata*, a traditional concoction of herbs used as a dose of vaccine prepared by a traditional healer (Green & Tuck 1997). Also, the surgical method can be used to separate the couple.

☐ *Bohloko bja popelo*/pain in the uterus

Bohloko bja popelo or *isilumo* in isiZulu is described as lower abdominal pain that is often consistent in nature but randomly starts as dysmenorrhoea in some instances. The condition signifies that a young female is either infertile or will struggle with falling pregnant. Its symptoms are similar to those of a pelvic infection, although traditional healers argue differently. The condition is also associated with sores in the uterus or pimples on the face. The diagnosis is determined through assessment and history-taking. The female will explain the signs and symptoms, after which the traditional healer will be able to diagnose the condition. Throwing of the bones also assists the traditional health care practitioner's diagnosis as there may be different causes of lower abdominal pain. The causes may be unknown in biomedicine but are commonly associated with jealousy from a traditional viewpoint and intended to render the female unable to conceive. In such instances, the traditional health care practitioner may prescribe oral herbal treatment to relieve the pain.

☐ *Tshipande/nnda*/pubic lice

Tshipande is described as lice found in the genitals and affects both male and female, and is diagnosed through its known signs and symptoms. The disease is called *itimbane* in Mozambique, *dinta* in Sepedi and *nnda* in Tshivenḓa, *izintwala in* isiZulu and *intakumba in* isiXhosa. *Crabs* is another term used colloquially to describe the condition. The lice are usually very small and will cause the individual to always feel itchy and continuously scratch their pubic area continuously. The lice may even spread to the body and destroy the sperm and ovaries. The traditional health care practitioner will normally interview the clients to determine what they have previously used to treat the condition. In certain instances, it is also attributed to a lack of proper hygiene or certain herbs used to cast a spell on an individual. Traditional health care practitioners use drinking herbs to resolve the condition. Topical herbs may also be used.

☐ *Gokhonya/rigoni/lekone*

Gokhonya mainly affects females and children and presents with wart-like sores in the vagina. This condition will affect the infant on the occiput during delivery, resulting in a baby born with a red mark on the occiput. The infection has different names depending on its cause, symptom and development. In Tshivenḓa, it is called *gokhonya*, based on its knocking effect on the baby during delivery. It is called *goni* and *lekone* in Sepedi because resembles a hawk snatching chickens from the mother hen for prey. It is called *ibala* in isiZulu because of the red discolouration that appears in the baby's occiput (Rikhotso 2018). *Rigoni* is another term used in other parts of the African continent, such as Mozambique (Green & Tuck 1997).

The baby whose mother is infected with *gokhonya* is born with a red mark on the occiput, resulting in the baby's diminished eye contact with the mother. The baby may also experience episodes of vomiting and respiratory distress. The mother may complain of vaginal itchiness, which is often relieved by scratching. There are different types of *gokhonya* warts. The first type is whitish in colour and is embedded in the floor of the vagina. A male may experience pain during sexual intercourse with an infected person. Another type is found below the vaginal clitoris. The third type protrudes from the vaginal walls (Mulaudzi & Makhubela-Nkondo 2006; Rikhotso 2018). It is believed that the infection contributes to high infant mortalities and is often part of unexplained deaths during infancy, such as cot deaths.

The history, signs and symptoms enable mothers, elderly females and traditional health care practitioners to diagnose the infection. While the causes are unknown, *gokhonya* is viewed as a congenital condition for females, but it can also be sexually transmitted from a male to a female. It is also believed that *rigoni* is related to the *nyoka*-related infection. In many African

cultures, including the VhaVenḓa, BaShona and the Vatsonga from Mozambique, to mention but a few, it is believed that there are infections caused by an invisible snake (*inyoka*). Such a view emanates from the belief that everyone has a snake residing inside their abdomen. It is further believed that the invisible snake protects human bodies from impurities by discharging fluids such as during menstruation, diarrhoea, through vomit and pus. However, when one is ill, the snake is supposed to cause cramps and pains that move from one part of the body to another, which is usually the explanation for the pain radiating to other parts of the body. It is believed that males usually suffer from *nyoka kundu* and females will be affected by *nyoka zoni*, both of which are transmissible through sexual intercourse (Green & Tuck 1997). The female will then infect the baby during delivery. The patients usually present with symptoms such as genito-urinary infections, yeast infections, prostate infections, urethritis and trichomoniasis.

There are different methods to excise the mother's *rigoni* sores. Some traditional health care practitioners use a razor blade to cut them. This method has been modified because of complications associated with the use of razors, such as profuse bleeding or infections. The majority of healers are now using herbs that are inserted in the vagina, while others prescribe oral treatment for the mother. The baby is often treated by topical treatment of herbs applied in the fontanelle and on the occiput where the marks are visible (Rikhotso 2018).

Western scholars associate the red occiput mark with Mongolian spots, described as a congenital birthmark that is often bluish-green to black in colour and oval-shaped (Gupta & Thappa 2013). The spots are considered benign and usually disappear after a year. The causes of *rigoni* are still unclear. More research is still required to determine the type of tissues that are excised from the vaginal walls.

Mafa/makgoma/meriti/mehlala

Different South African and Mozambican authors have attempted to explain this condition. It is called *thavhu* in Kenya, *amakombela* in Zambia, *boswagadi* is Setswana, *meriti* and *mehlala* in Sepedi and *mafa* in Tshivenḓa. *Makgoma* has been classified as a condition that emanates from the transgression of societal norms, rituals, culturally-bound syndromes or taboos. For example, the death of a husband should be followed with a cleansing ritual or ceremony, the failure of which renders the widow unclean or contaminated. As such, uncleanliness will infect any male that has sexual intercourse with an unclean female (Burman 2018).

The signs and symptoms of *makgoma* are a headache, loss of appetite, weight loss, coughing, tiredness, swollen legs, diarrhoea, sores and wounds. In most cases, these signs and symptoms could be mistaken for HIV and AIDS. The face and body may also be swollen. Some of the traditional health care practitioners

in Waterberg in the Limpopo province were convinced that the manifestations of *makgoma* are the same as those of HIV and AIDS (Maema et al. 2020).

According to Mahoko (1997), there are impersonal causes of the infection, such as melancholic episodes, that people experience when they encounter certain life events. The gloomy shadows or melancholic episodes are related to life events such as pregnancy, death and abortion. It is believed such events and experiences render females unclean, contaminated or impure because of the shadows of these events hanging around them. These shadows are referred to as *meriti* or *mehlala*, and the people affected are enjoined to go for a specific cleansing ritual following an abortion, miscarriage or death of a spouse. Failure to undergo the ritual constitutes a cultural transgression that could be detrimental to a male having sexual intercourse with the infected female (Green & Tuck 1997; Maema et al. 2020; Mahoko 1997; Mulaudzi & Makhubela-Nkondo 2006).

In such instances, traditional health care practitioners diagnose the client or patient through divination to establish the causes of the disease. In such instances, treatment is often provided by means of ritual cleansing with herbs. Sexual cleansing is undertaken to cleanse the surviving spouse of the deceased. There are other methods in existence, such as the anointing method in terms of which a widow or widower is anointed with a mixture of castor oil and cornmeal. Other methods require the widow or widower to skip or slide over a particular animal to be cleansed of the spirit of the deceased partner (Moyo & Muller 2011). There is also the cultural gathering of the clan to appease the gods for the committed transgression.

Mokabe

Mokabe is a testicular swelling resulting from sexual intercourse with a female who is still in postpartum confinement (Maema et al. 2020). It is believed that a female in such a state still has vaginal discharge, which renders them unclean, dirty or contaminated/polluted (Mulaudzi & Makhubela-Nkondo 2006). The diagnosis is confirmed through history-taking and assessment, in which case the traditional health care practitioner will interview the male and assess their testis to determine the extent of the problem and the swelling.

The causes of the *mokabe* condition have an affinity with a taboo. Accordingly, the female is supposed to rest and abstain from sexual intercourse for a specified period of time, which can range from three months to a year following childbirth. The period is viewed as a post-confinement period during which a male who has sexual intercourse with a female shall have transgressed societal norms and suffer from *mokabe*. The other cause emanates from a male engaging in sexual intercourse with a female who is in menopause. It is believed that the male will suffer from a swollen scrotum because of the semen accumulating in it. Similar to most, or all the STIs presented and

discussed in this chapter, *mokabe* is also treated by orally administered herbal treatment. A cleansing ceremony may also be prescribed, depending on the circumstances that necessitated such cleansing, in the first place.

Tshikwilimimba/distended abdomen

Tshikwilimimba is a disease that develops in a menopausal female engaging in sexual intercourse with a virile male. The menopausal female is viewed as unclean and a cause of the disease because the menopausal stage is considered 'a disease condition' (Loustanou & Sobo 1997 as cited in Mulaudzi 2009). The female will then display a distended abdomen because of the accumulated semen in the abdomen. In contradistinction, the male will present with a swollen scrotum (described as the *mokabe* in Sepedi). A history of the disease will be taken as a diagnostic measure to establish and obtain further information to assist in the process. The diagnosis is undertaken during the assessment on the basis of the signs and symptoms observed for both the male and female involved, followed by a prescription of herbal treatment consisting of both partners' urine mixed with medicine which they are expected to drink. It is envisaged that the male's swollen scrotum and the female's distended abdomen would then subside (Mulaudzi 2009).

Aetiology or causes of sexually transmitted infections (*malwadze a vhudzekani*)

People hold different ideas and opinions about the logic of the aetiology of diseases. Such logic is instrumental in shaping their health-related behaviour. In this regard, traditional health care practitioners use physical manifestations and symptoms to diagnose and name the type of STIs with which the client is presenting. The causes of STIs are classified as either natural or unnatural. In the traditional indigenous context, the natural causes of STIs are attributable to the transmission through sexual intercourse, while the unnatural causes are related to the transgression of societal norms, practices or rituals.

Pollution or uncleanliness is also viewed as one of the causes of sexually transmitted or related infections (Green & Tuck 1997; McNeill 2009). Patriarchally induced stereotyping has rendered females as primary carriers of these STIs. Such views further perpetuate the covert violence and discrimination against females and stigmatisation of STIs, both of which also contribute to patients refusing hospital and clinical care.

Uncleanliness is a period in a female's life characterised by developments such as menstruation and postpartum or post-abortion discharges. Females are fingered as the main carriers of contagious and infectious 'dirt' based on the perception that a moist vagina is a breeding site for infectious bacterial 'dirt' that causes infection (Mulaudzi 2009). Accordingly, males are not expected to have sexual intercourse with a menstruating female because their virility and libido would supposedly be weakened (rendered impotent).

Post-abortion discharges are more infectious and may lead to the male's death in the event that they are not treated early. In modern Western biomedicine, the subject of post-abortion is explained in the context of dilatation and curettage (D&C) performed after an abortion for the purpose of cleansing or purifying her from any possible infection. Such an exegesis premises on the notion that the unclean female will be an infection transmitter. Furthermore, the D&C perspective proposes that menstruation in itself is immanently a cleansing process. Therefore, the affected female ought to wait for natural cleansing. As postpartum discharges are also viewed as infectious, females are then advised to practice postpartum isolation and avoid sexual intercourse before the resumption of their menstruation cycle. This D&C-orientated explanation corresponds with puerperal sepsis that could occur in a female's poor post-delivery care.

Transgression of culturally stipulated rituals includes mourning periods, postpartum periods and appeasing the ancestors. Therefore, it is implied that certain behavioural, attitudinal and moral practices and conduct are expected in acknowledgement, recognition, acceptance and respect of the symbolic value of these cultural prescripts and codes. For example, it is expected that other people's marriages should be treated with the reverence they deserve. It is in such precise contexts that issues of infidelity, promiscuity and extramarital affairs would be viewed as highly immoral, abominable, reprobate and reprehensible practices. There are also periods in females's lives during which any form of sexual or amorous activity is strictly forbidden. Such prohibition occurs during menopause and widowhood, and any offending female could contract *tshikwilimimba* (distended abdomen). During widowhood, females are forbidden from any sexual activity for a period lasting three months to a year. Females were expected to undergo a cleansing ritual after the mourning period. Failure to observe this ritual could lead to a sexually-linked disease called *mafa* (related to death) (Mulaudzi & Makhubela-Nkondo 2006).

A study conducted among the Bapedi in Limpopo province confirmed that community members were optimally conversant with the nexus between STIs and sexual intercourse with multiple partners. From that perspective alone, the community was capable of refraining from sexually risky behaviour and practising self-care. Such evidence-based declarations are valuable insofar as capacitating health care practitioners to provide health education to their patients that are in accord with culturally safe practices (Semenya & Potgieter 2013, p. 1047).

Preventive and promotive measures

A Nigerian study conducted by Kadiri, Ahmada and Mustaffaa (2014) concerning cultural sensitivity in STIs among the youth revealed that factors such as cultural practices, norms and taboos, language, religious values and beliefs affected the sexual behaviour of the youth. Cultural practices may

either be negative or positive. For example, females's circumcision or genital mutilation – which is rife in central Africa – is supposedly used to reduce females's libido and prevent them from being promiscuous. Participants in the same study also protested that society accepted and allowed males to have concubines outside their marriage. Clearly, this suggested that discriminatory standards were applied to elevate males to some status of superiority and moral entitlement to behave as wantonly as they pleased (Kadiri et al. 2014). The practice of polygamy was cited as a relatively defensible example to prevent STIs as the males would be confined to their formal married wives only, which is tenable in tracing contact in cases. Nonetheless, infidelity is still common in polygamous marriages, as confirmed by Nyathikazi's (2013) KwaZulu-Natal study, which revealed that polygamy was not necessarily a deterrent to males's extramarital relationships exacerbate HIV and AIDS and other STI transmissions.

Societal norms and taboos are viewed as helpful in defining people's acceptable behaviour (Kadiri et al. 2014). Therefore, aberrant and transgressive conduct is considered a contravention leading to the prevalence of STIs. The practice of widow inheritance was also cited as facilitating the spread of sexual infections, such as HIV and AIDS (Mswela 2009). Widow inheritance (levirate) is a practice in terms of which a widow is allocated one of the deceased husband's brothers to promote succession of the family lineage or to protect and keep the wealth of the family from falling into the hands of outsiders. Sivhabu and Visser (2019) argue that abstinence is still one of the viable cultural practices that could benefit the cause of combating the spread of STIs.

Treatment of sexually transmitted infections

The treatment of STIs is not standardised and differs according to the approach adopted by a traditional health care practitioner. Ethnobotany studies conducted by De Wet and Van Vuuren (2012) and Semenya and Potgieter (2013) identified more than 52 plant species used for the treatment of STIs. Evidently, traditional health care practitioners do not rely on a single treatment modality or plant species to treat STIs. They often mix these plants and make their own herbal medicines. The herbs are prescribed and administered orally, rectally and topically and treat more than one condition (Semenya & Potgieter 2013). The herbs are also prepared using decoction, infusion and crushing (Ajibesin, Bala & Umoh 2011). Furthermore, the treatment is also accompanied by rituals that are performed to cleanse the affected male or female in case some form of cultural transgressions is identified.

There are basically five plant species that are commonly used in the treatment of different types of STIs (see Table 9.1) (Maema, Potgieter & Samie 2019). A Nigerian study conducted by Ajibesin et al. (2011) emphasises the need to document the plant species used to treat STIs to ensure continuity'

lest the knowledge disappears into oblivion. In this regard, there is great concern regarding the extant loss of medicinal plants and plantations because of unplanned urbanisation and deforestation (Maema et al. 2019).

Medicinal plants most frequently used to treat sexually transmitted infections

Table 9.1 is a depiction of different plant species used by traditional African health care practitioners to treat STIs. These plant species are known as *Catharanthus roseus* (L.) G. Don, *Agave sisalana* Perrine ex Engelm, *Ricinus communis* L., *Opuntia ficus-indica* L. Mill, *Senna didymobotrya* (Fresen) and *Solanum elaeagnifolium* Cav.

Table 9.1 depicts plants or herbs that have been proven to have antimicrobial activities and are dispensed by traditional health care practitioners to their clients or patients for the treatment of STIs. One plant can treat more than

TABLE 9.1: Medicinal plants most frequently used to treat sexually transmitted infections.

Plant species	Sexually transmitted infections
Catharanthus roseus (L.) G. Don	• *Dorobo/toropo*/gonorrhoea • Chlamydia • *Thusula*/syphilis • HIV and AIDS • *Tshovela*/genital warts
Agave sisalana Perrine ex Engelm	• *Dorobo/toropo*/gonorrhoea • Chlamydia • *Thusula*/syphilis • *Tshovela*/genital warts • *Makgoma*
Opuntia ficus-indica L. Mill	• *Dorobo/toropo*/gonorrhoea • Chlamydia • *Thusula*/syphilis • *Tshovela*/genital warts • *Makgoma*
Ricinus communis L.	• *Dorobo/toropo*/gonorrhoea • Chlamydia • *Thusula*/syphilis • *Makgoma*
Senna didymobotrya (Fresen)	• *Dorobo/toropo*/gonorrhoea • Chlamydia • *Thusula*/syphilis • *Tshovela*/genital warts • *Mokabe*
Solanum elaeagnifolium Cav.	• *Dorobo/toropo*/gonorrhoea • Chlamydia • *Thusula*/syphilis • *Tshovela*/genital warts • *Mokabe* • HIV and AIDS

Source: Adopted from Maema et al. (2019).

one illness. While Table 9.1 categorically depicts only the identifiable characterisation of the main five plant species, it still needs to be established whether or not the plants have some aphrodisiac effects on the traditional health care practitioners' clients.

Recommendations

The information on causes, diagnosis and treatment modalities will assist the health care workers and health care planners in finding ways to assess, plan and implement good measures and treatments to address STIs. Traditional health care practitioners can play an important role in the education and preventive methods of STIs. For example, they can contribute by distributing condoms and encouraging their clients to use them. Beneficial cultural preventive and promotive measures – such as abstinence – should be actively promoted and not merely incidentally or occasionally. However, practices that influence the oppression of females and promote patriarchy should be exposed and discouraged vehemently; or modified for gender-sensitive purposes. There is a need to integrate both modern biomedical and indigenous medicinal practices, which will facilitate more scientific research into promotive, preventive and diagnostic measures for STIs.

Conclusion

The chapter addressed indigenous STIs as viewed from various community perspectives. The perceptions, beliefs and practices of community members should not be overlooked, particularly in respect of the naming, aetiology and treatment of these illnesses. We have learned about new STIs that are known by the community and those that are known in modern biomedicine but named and understood differently by respective communities in different parts of the African continent. The information on plant species used for treatment is also informative and will assist those who are interested in further research and those desiring to practice in the sphere of treating STIs in primary health care settings. Understanding indigenous STI perspectives will enable health care workers to probe further during history-taking of clients that present themselves in clinics or hospitals explaining diseases that may have been caused by culturally defined transgressions. Thus, the biomedically trained health care workers will be able to make informed decisions regarding the referral of clients or patients to the next health care provider, such as the traditional care practitioner.

Glossary

- ***Bapedi*:** A tribe that is a subgroup of the Sotho people who live in the northern part of South Africa.

- ***bohloko bja popelo*:** Pain in the uterus
- ***divhu* (*u wela*):** Literally translated as 'to fall in'. This is a type of sexually transmitted infection that occurs when a male sleeps with a female who had an abortion.
- ***dorobo*:** A type of sexually transmitted infection that is diagnosed symptomatically when a male or female experiences heavy yellowish discharge.
- ***Dzithevhula*:** A feast in which traditional beer is spilt during a ceremony used to appease and connect with the ancestors.
- ***fembo*:** A practice by which the traditional healer connects the patient with their ancestors by using the patient's smell as a method of diagnosis.
- ***gokhonya*:** A type of sexually transmitted infection wherein babies are born with a red mark on the occiput.
- ***goni* (*lekone*):** An eagle (in this case, it refers to a type of a sexually transmitted infection which is similar to *gokhonya*).
- ***ibala*:** The same disease as *gokhonya*; however, in this case the infection is named based on the red discolouration that is found on the occiput of the affected baby.
- ***mafa* (*boswagadi*, *meriti*, *mehlala*, *makgome*):** A type of sexually transmitted infection that occurs if a male has had sexual intercourse with a widow.
- ***malwadze*:** Illness.
- ***malwadze a vhasadzi*:** Female infection.
- **mokabe:** A male who has a swollen scrotum due to engaging in sexual intercourse with a female who is going through menopause.
- ***thusula*, *thosola*, *gcunshula*:** A type of sexually transmitted infection with complications including sores all over the body.
- ***tshikwilimba*:** A disease that develops when a menopausal female engages in sexual intercourse with a male who is still virile.
- ***tshimbambaila*, *lkhubalo lenja*, *u reiwa*, *runyoka*:** A sexually transmitted infection that occurs when a male has had sexual intercourse with a female who is locked.
- ***tshipande* (*nnda*):** Lice found in the genitals
- ***tshovela*, *tshofela*, cauliflower:** A growth that develops on the genital area
- ***vhasadzi*:** Females

Chapter 10

Indigenous health care practices in the treatment of mental illness in South Africa

Miriam Moagi
Department of Nursing,
Faculty of Health Sciences, School of Nursing Science,
North-West University,
Mafikeng, South Africa

Mokgobola Thobakgale
Department of Nursing,
Faculty of Health Sciences, School of Health Care Sciences,
University of Limpopo,
Turfloop, South Africa

Madimetja Magoro
Tompi Seleka College of Agriculture,
Agriculture Extension,
Economics and Partnerships,
College of Agriculture,
Marble Hall, South Africa

Abstract

Indigenous health care practices in Africa are practised by local communities who have close relationships with traditional health care practitioners as part of their culture and belief systems. Also, indigenous health care practices play a role in addressing mental health care systems in different communities in Africa.

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Traditional health care practitioners are guided by ancestral spirits in addressing their cultural practices and customs. The purpose of this chapter is to demonstrate the understanding of mental illness and the treatment thereof from an indigenous African perspective. This chapter discusses the traditional health care practitioners' views on the causes, diagnoses and treatment that a mentally ill patient receives from traditional health care practitioners. It also outlines the diverse treatment and care that mentally ill persons receive from traditional health care practitioners. Thus, health care professionals should respect and take into consideration patients' cultural values and beliefs.

Treatment of mental illness

Mental illness is a health care problem that disturbs an individual's thinking and capacity to cope with everyday life (Auerbach et al. 2018). It is estimated that around one billion people globally have a mental or substance use disorder. Mental health can incorporate mental health disorders, substance use disorders and neurodevelopmental disorders (WHO 2019). Additionally, Ngobe, Semenya and Sodi (2021) in their study found that globally, around 450 million people suffer from mental illness and about 1 million people commit suicide every year because of mental health disorders.

In Africa, *bogafi* (mental illness) is highly prevalent, and people consult traditional health care practitioners daily in search of treatment (Mokgobi 2013). These *dingaka* [traditional health care practitioners] are part and parcel of African traditional belief systems (Duncan, Swartz & Kathard 2011). There is evidence throughout African communities that indigenous health care practices always played an important role in community mental health care services, especially in people diagnosed with mental illness (Madzhie, Mashamba & Takalani 2014). These indigenous practices are guided by ancestral spirits and are based on cultural practices and customs. The words 'indigenous health care practices' and 'traditional health care practices' are used interchangeably in this chapter.

Indigenous health care practices are defined as local knowledge developed over centuries of experimentation and are passed orally from generation to generation (Donato-Kinomis 2016), whereas traditional health care practices are defined as knowledge and practices used in the diagnosis, prevention and elimination of physical, mental and social imbalances with reliance on practical experiences and observations handed down from generation to generation, verbally or in writing.

Traditional health care practices are part and parcel of African traditional beliefs, whereby people have close relationships with the traditions that are shared (Abbo 2011). As a result, traditional health care practitioners understand

TABLE 10.1: Mental illness typology.

Type 1: Biological from birth	Type 2: Witchcraft induced	Type 3: Ancestral calling	Type 4: Psychological disorders
No treatment – natural *motho wa modimo*	Treatment using rituals or completely not treatable	Treatment – undergo *go thwasa* (process to become a traditional healer)	Treatment through administering smoke incense

and treat mentally ill patients because they have knowledge and understanding of their environment (Mashamaite 2015).

Traditional health care practitioners are important in treating mental illness in many parts of the world, including Africa (Musyimi et al. 2018). According to Nompumelelo et al. (2019), there is a traditional health care practitioner in every community, and these traditional health care practitioners have established a relationship of trust with the communities they serve. In Ethiopia, traditional health care practitioners are important in the community that they serve and remain part of the health care system (Shizha & Charema 2011). Similarly, in Uganda, a traditional health care practitioner present in every community bears the burden of the community's mental illnesses (Abbo 2011). In Kenya, on the contrary, more than 70% of the population relies on traditional health care practitioners for the treatment of mental illness because they are easily accessible (Ndetei 2013).

In South Africa, mental illness is believed to be present when an individual behaves inappropriately and shows signs and symptoms of mental illness (Mufamadi & Sodi 2010). *Botsenwa/bogafa/lefofonyane* [mental illness] is perceived as a psychological disorder that might emanate from biological *badimo* [ancestors] and *boloi* [witchcraft]. This understanding of mental illness in an African context will always be complicated as it also attributes the illness to witchcraft (Nevhudoli 2018).

Mental illness is referred to as *bogafi* in Sepedi, *botsenwa* in Setswana, *ukuphambana* in isiXhosa or *ukuhlanya* in isiZulu. All these terms are derogatory; for example, *bogafi* refers to an abnormal behaviour, while *botsenwa* means that some evil spirits are in control and the person is no longer in control of the self. Mufamadi and Sodi (2010) further postulated that mental illness may be confused with ancestral calling. A typology of mental illness is represented in Table 10.1.

Type 1: Biological from birth

In South Africa, mental illness is defined as a 'condition that disrupts a person's thinking, mood, feeling and ability to relate to others on daily functioning because of brain or western dysfunction' (Nevhudoli 2018).

Several factors can lead to giving birth to a mentally disturbed child. In African culture, this is called *seetso,* when one laughs at or torments a mentally ill person.

Type 2: Witchcraft induced

In a study conducted by Madzhie et al. (2014), it was revealed that mental illness is caused by ancestors, witchcraft and disturbances in social relationships, disappearing from home, talking to invisible people, showing aggressive behaviour towards others and walking naked in public spaces. Among the Shona people of Zimbabwe, mental illness is attributed to witchcraft, which resulted from *kuroiwa* [being bewitched]. According to Gelfand (1979), an individual struggling with mental illness [*kupenga*] in Xitsonga will present with hysterical behaviour and an imbalance in their mental health.

Type 3: Ancestral calling

Nevhudoli (2018) defined mental illness as communication between the ancestors and living individuals. Some of the symptoms that mentally ill people may present with may be regarded as the manifestation of spiritual problems symbolising ancestral calling. It is viewed that any form of defying the ancestral calling might lead to an individual being mentally disturbed. According to Kubeka (2016), 'when an individual in the Zulu culture has an ancestral calling, they sometimes present symptoms and signs that are similar to those of a person with mental illness/psychosis'. Kubeka (2016) also indicated that the person must go through *ukuthwasa* (a process undertaken to become a traditional health care practitioner) to be cured.

Type 4: Psychological disorders

According to Mufamadi (2004), health and diseases can be understood from imperfect divisions of mind, body, spiritual and physical state. Mpofu et al. (2011) maintained that indigenous health care practices have proven to be more successful in treating mental illness because of their nature. Sodi and Bojuwoye (2011) posited that culture as an important factor in health care has its distinctive conceptualisation of mental illness. Equally, Thobakgale (2021) pointed out that culture plays an important role in guiding, influencing and demonstrating social behaviour in an individual and society. Similarly, Mashamaite (2015) emphasised that each culture has its unique explanatory models of describing mental illness that can be understood within its respective worldview. According to White (2015), culture impacts the beliefs, practices, behaviours, health care and even the choice of treatment. According to Shai (2012), different cultures in the world have different ways of explaining mental illness.

African perspective of mental illness

Traditional health care practitioners use several methods to determine the origins of mental illness. When the ancestors are neglected, they become angry and send them misfortunes (mental illness) as a form of punishment. In that way, a mentally ill person could see things that other people are not seeing (Nevhudoli 2018). This is supported by Sorsdahl et al. (2009), who found that mental illness problems in many indigenous communities are perceived to be because of ancestors or bewitchment. Many African people believe that mental illness is because of witchcraft [*boloi*]. Witchcraft is another way that traditional health care practitioners perceive as the cause of mental illness, whereby it is alleged that people with evil powers could also make others mentally ill.

In Zimbabwe, Muchinako, Mabvurira and Chinyenze (2013) revealed that the Shona people share the same belief that ancestors [*vadzimu*] are responsible for mental illness. In Malawi, mental illness is described as *vimbuza*, a type of mental illness that manifests as a dissociative disorder, which is caused by bad ancestral spirits (Peltzer 1989). The mental illness will be diagnosed by a traditional health care practitioner [*nganga*] who will interpret and describe the cause of mental illness in an individual. Additionally, stubbornness or contempt for ancestral messages is interpreted as a reason for mental illness (Muchinako et al. 2013). Similarly, among the Bambara people in Mali, the essential concept regarding mental illness is founded on elements of nature, earth, water and fire (Koumare 1983). Each element can exert a specific influence on certain organs of the body.

The types of indigenous mental health care in Africa

In South Africa, mental illness among indigenous communities is referred to as *amafufunyana* (Sigida 2016). *Amafufunyana* is 'a hysterical condition characterised by people speaking in an eccentric muffled voice in a language that cannot be understood and acting strange and unexpected behaviour' (Sigida 2016). This condition is believed to be induced by *boloi* that has led to possession by various spirits that may lead an individual to then speak in tongues or different languages understood only by the self (Makhanya 2012). According to Nare, Pienaar and Mphuthi (2018), the common features of *amafufunyane* (isiXhoza) or *mafonfonyane* (Sesotho) are when a person presents with bizarre content of speech, running away from home, talking alone or laughing inappropriately, and undressing in public. In isiXhosa, mental illness is sometimes referred to as *ukuphambana*. *Ukuphambana* is equivalent to *ukuhlanya* or *ukuphanjanelwa yikhanda* in isiZulu, which refers to a psychotic disorder.

According to Nzewi (1989), cited in Mashamaite (2015), in Nigeria, mental illness is called *onye ala*. The individual suffering from this type of mental illness is not dangerous. Other categories are *isi mgbaka*, *isi mmebi* and *agwu*. When a person is suffering from this type of mental illness, it is said that they are possessed. Another mental illness is *akaliogoli* or *efuledu*; this is a similar illness, just the names are used interchangeably. If one is afflicted with *akaligoli* or *efulefu,* it is believed that they are not mentally ill but have a defect. People suffering from these conditions are believed to have failed to introject parental norms and values in the process of development.

Traditional health care practitioners' diagnosis of mental illness

Diagnosis (*go phekolwa/u thathuvhiwa*/to be assessed)

Traditional health care practitioners are guided by the signs and symptoms from an assessment of a person to get the diagnosis. The signs and symptoms in some cases are in the form of the traditional health care practitioner's senses, such as feeling the pain that the client (*molwetši/mulwadze/patient*) feels. The pain could be felt even before the traditional health care practitioner asks what the problem is before the client and family present the problem (Thobakgale 2021). Thobakgale (2021) further revealed that for a traditional health care practitioner to come up with a diagnosis, they are supposed to make a comprehensive assessment using the following methods:

- Family involvement.
- Spiritual assessment.
- Divination.

In the diagnosis of a client, the traditional health care practitioner values the family's involvement in every step to be taken. Diagnosis is a technique used to discover the origins of the disease and give treatment according to the clinical manifestations presented or observed (Nevhutoli 2018; Sodi et al. 2011; Thobakgale 2021).

The diagnostic technique used depends on the nature of the illness (Mashamba 2009). Mufamadi (2001) posited that diagnosis is a process that is linked to a client's culture. In disagreement, Latif (2010) indicated that some researchers allege that the method used by traditional health care practitioners to diagnose mental illnesses is grounded on beliefs without an in-depth investigation. A relational approach suggests that an agreement should be reached between the traditional health care practitioner and the family of the client to establish the nature of the illness.

According to Swartz (1998, cited in Nevhudoli 2018), the traditional health care practitioner diagnosis is related to the causes of mental illness, and this diagnosis is made through different methods, such as divination. Divination is a method whereby the traditional health care practitioner throws the bones and performs *ukufemba* (smelling a person's problems or other issues) (Thobakgale 2021), bone throwing and the use of senses such as observation, tactile and hearing. The traditional health care practitioner diagnosis is the most comprehensive because the family and the environment where the mentally ill person lives and works will be checked. Different assessment methods, such as family involvement, spiritual assessment and divination, can be used to assist in the diagnosis of mental illness, as indicated earlier.

Family involvement

It is important to involve the family in every step of the health care and treatment of a mentally ill person. The reason for family involvement is that sometimes what the spirits reveal through the traditional health care practitioner could need confirmation or clarification from family members. According to Thobakgale (2021), in South Africa, there are set rules or unwritten agreements that disapprove or prohibit traditional health care practitioners from acting or making decisions that involve the treatment of their clients without involving the family. Collateral history or family history is considered an important source of information that can guide the diagnosis of a client. This was confirmed by Sigidi (2015) that family involvement during the assessment is very important and could lead to an appropriate diagnosis. Family members are always with the client, and they can reliably give a history of the illness (prior and current).

Ancestral spirit (*moya wa badimo*)

Nare et al. (2018) reported that traditional health care practitioners who have a special bond with their ancestors are possessed by their ancestor's spirit and enter the two-way conversation for any revelation that serves as part of the assessment and treatment. These traditional health care practitioners use the ancestral spirit to assess and reveal the client's problem or illness, the causes and how to solve it. Traditional health care practitioners' sense of the mind helps to identify the problem. They use their 'sixth sense' (perception or instinct or the ability to communicate with the ancestors), extrasensory perception (ESP), clairvoyance, premonition or intuition to guide them when assessing clients (Rezaei & Saghazadeh 2019; Merceer 2013). Assessment through the senses refers to the physical experience of the client's illness and the findings by the traditional health care practitioner. Alternatively, the traditional health care practitioner links clients directly with their ancestors, who then answer the questions asked (Ramaube 2018).

Divination

Divination is the art that pursues to foresee or foretell future secret events or knowledge that could be an interpretation of omens or by the aid of supernatural powers (Banze 2014; Mokgethi 2018). According to Ozioma and Chinwe (2019), traditional health care practitioners consider divination as the principal part of diagnosing diseases and illnesses. Traditional, health care practitioners commonly use the two assessment methods of *go laola* [bone throwing] and *go nyakišiša/ukufemba* to diagnose a client.

T Bone throwing (*go laola*)

In the study conducted by Mufamadi (2010), *go laola* (*using ditaola/divination bones*) is an approach used by traditional health care practitioners to diagnose a person with mental illness. Bone throwing is the most preferred indigenous method of diagnosing an illness. The purpose of *go laola* for the traditional health care practitioner is to consult with the ancestors [*badimo*] to ask for guidance and to get a clear understanding of what troubles the client is facing, what could be the cause and what could be given to the client as a treatment or a preventive strategy. The bone throwing conducted by the traditional health care practitioner is linked well with ancestral spirits and possible treatment and prevention and is determined by their guidance. The falling of bones determines the whole process of treatment. Traditional health care practitioners are guided by the position of the bones fallen, which is defined as floor x-ray [*lewa*] affectional known in the local languages. The treatment can be administered through traditional medicine and rituals.

Ukufemba

Ukufemba is an assessment method where a traditional health care practitioner can sniff or smell or foretell the hidden objects that are inflicted on a person's body or mind to cause mental illness. *Ukufemba* is performed by using the tail of a cow or horse called *leshoba,* while others use a dowsing pendulum which in Sepedi is called *mankgonyane* (Thobakgale 2021).

Indigenous mental illness treatment methods

Different treatment methods are used by traditional health care practitioners in South African culture, which include herbal medication [*muthi*] made from plants, rituals that explain the causes of mental illness, and animal and minerals mixture with spiritual significance (Busia 2016). The most outstanding feature of the treatment is its holistic approach, including the treatment of the mind, the body, the patient's family and the patient's environment (Konadu 2006; Mashamba 2007). The Diagnostic and Statistical Manual of Mental Disorders

(DSM 5) diagnostic criteria are well thought out to be a guide for the assessment and diagnosis of mental illness in the western approach. Nevertheless, there is still a gap in providing for and assessing, diagnosing, as well as treating cultural illnesses (Clark et al. 2017). Traditional health care practitioners usually involve family throughout the treatment of a mentally ill person as the mentally ill person is unable to make informed decisions, and good practice is also employed by health care practitioners in their practice.

In addition, treatment of mental illness could be spiritual initiation (*tlhahlo ya semoya/go thwasa*), ritual performance and herbal medicine [*diša*]. Juro (2016) added that there are some performances of the rites in the treatment of mental illness. However, mental illness can also be treated with herbs (Maboea 2002). Amulets, fetishes or rituals are some of the treatment methods for mental illness, and they are also used as preventive means against further illnesses (Mugambi 1989).

Another treatment strategy is communicating with ancestors through the performance of rituals. Mpofu et al. (2011) indicated that African indigenous health care practitioners have more successful evidence of treating mental illness. In support, Mashamaite (2015) asserted that traditional health care practitioners could understand and treat the patients' mental illnesses because of their knowledge and understanding of the patients' illnesses.

Sodi (1998) discovered that before the traditional health care practitioner can start the treatment, patients must first engage in rituals as part of the belief system. These rituals include the slaughtering of an animal, which in most cases is a goat, to appease and to make peace with the ancestors. Thereafter, as part of the treatment plan, a patient may be advised to go and perform some sort of purification in a nearby river. As a result, comprehensive rituals are considered therapy to let the possessing ancestral spirits communicate with the patient and the family.

There is evidence of success by traditional health care practitioners in treating mental illness than physical conditions (Mpofu et al. 2011). Hence, traditional health care practitioners are also preferred because of their accessibility and affordability and their vital qualities in caring for mentally ill people (Payyappallimana 2010). The indigenous healing practices cannot be taken too lightly, as they are perceived in most African countries, South Africa included, as the prevailing methods (Sorketti, Zainal & Habil 2012). The same authors asserted that traditional health care practitioners are seen as the primary agents in African societies. According to Mashamaite (2015), traditional health care practitioners can choose to admit mentally ill patients to their homes for a short period during the treatment process, and this will help to monitor the progress and observe any changes in the patient's condition. In support, Ngobe et al. (2021) indicated that traditional health care practitioners in Eswatini keep mentally ill patients in their homes for

treatment until they recover. However, other traditional health care practitioners indicated that they treat mentally ill patients in their homes under the supervision of their families to ensure that they conform to treatment to reduce the severity of mental illness.

Ngobe et al. (2021) further outlined that initiation [*kwetfwasa*] in Siswati is used to treat people with mental illness because of the ancestral calling to become traditional health care practitioners. They also stated that a person in the process of initiation as a treatment for mental illness would only recuperate once they acknowledged the ancestral calling and completed training. The training includes learning how to be humble to the ancestors and washing in the blood of sacrificed animals.

Other methods used by traditional health care practitioners to treat an individual who is mentally ill include the slaughtering of a goat as an offering to ancestors so that they forgive the patients for breaking the cultural 'taboos'. Therefore, rituals that will be followed by patients' cleansing will include, among others, bathing to purify patients' bodies, steaming, induced vomiting and inhaling herbs. It is believed that these 'rituals' may influence the mental health of an individual positively by creating harmony and peace in the mind of a patient and evicting evil spirits in their body (Ngobe et al. 2021).

Mashamaite (2015) discovered another belief system about the method and treatment of mental illnesses, whereby some traditional health care practitioners believe that when a mentally ill person is roaming around aimlessly and disappearing from their homes, the traditional health care practitioners would mix a python skin with herb, wrap them together and put that at the patients' home to stop them from disappearing. According to traditional health care practitioners, the python skin is used because there is a belief that when the stomach of a python is full, it does not move until it is hungry.

Mashamaite (2015) had the opinion that people's beliefs concerning mental illness should be understood and known. Other rituals in the treatment of a mental illness are done to welcome home a discharged mental illness patient. Mashamaite (2015) further indicated that to celebrate the healing, an animal will be slaughtered to bound and soothe the patient's relationship with the ancestors. Therefore, a patient, as a sign of appreciating their ancestors, will wear a wristband from the skin of the slaughtered animal.

Implications for health care professionals

In South Africa, rural communities are mostly impoverished and lack resources, which results in community members not getting the satisfactory health care that they deserve. This can be averted by the health care system by allowing traditional health care practitioners to provide care to the community.

Traditional health care practitioners are trusted by community members, and a majority of traditional health care practitioners are part of the communities they practise (Ndetei 2013). It is, therefore, important for traditional health care practitioners to work in collaboration with mental health care providers as this will help them to access and use DSM 5 diagnostic criteria to assess and diagnose people with mental illness (American Psychiatric Association [APA] 2013, p. 21). The majority of mentally ill people consult traditional health care practitioners first before consulting the mental health care practitioners. As such, mental health care practitioners should accept and provide treatment to mentally ill people who are also using traditional medication.

Recommendations

Indigenous practices in Africa are part and parcel of African traditional belief systems. African people share a special bond with traditional health care practitioners, as they live in the same community and are regarded as indigenous knowledge holders. Secondly, the community and traditional health care practitioners share similar values and cultures; as such, communities trust their knowledge and understanding in treating people with mental illness. It is, thus, important for health care professionals to note the importance of culture in health care, given as follows:

- To promote the best practices, mental health care professionals need to know and understand the diagnosis and treatment of mentally ill people by indigenous health care practitioners.
- To avoid unsafe drug-herb interactions, there should be proper communication between the western medical community and indigenous knowledge holders. Failure to recognise and integrate traditional medication into western medical practices can lead to adverse effects, because of the mixing of incompatible herbs and pharmaceuticals, as such, weakening the patient-centred model of care.
- To avoid undermining each other and encourage a relationship of trust between mental health care professionals and traditional health care practitioners, the two health care systems have to close the communication gap and allow mentally ill persons to freely choose the type of service that they would like without fear of intimidation.

Conclusion

Mental health care services are to be rendered in an open and conducive environment. Health care providers should familiarise themselves with the cultures and beliefs of the communities where they work so as to better understand their health care systems. The western-trained health care professionals should embrace the African ways of understanding and treating mental illness and work closely with traditional health care practitioners in

mental health care programmes. A health care professional should be an important person in coordinating health care in the communities they serve and must be involved in primary, secondary and tertiary activities. Health care professionals together with traditional health care practitioners should engage in how to work together in providing treatment to people who are mentally ill. The important role played by traditional health care practitioners in providing health care to people who are mentally ill, especially in rural areas, has to be accentuated. Indigenous health care practices need to be appraised and given due acknowledgement to address their effectiveness and accessibility to the benefit of indigenous people.

Glossary

- ***amafufunyane/botsenwa/bogafa/kupenga*:** A person who shows signs of mental illness or challenges
- ***badimo/vadzimu*:** Ancestors
- ***bogafi/botsenwa/ukuphambana/ukuhlanya/kupenga/vimbuza/onye ala*:** Mental illness
- ***boloi*:** Relates to witchcraft acts by harming other people targeted
- ***diša*:** Ritual performance and herbal medicine
- ***ditaola*:** Divination bones
- ***go laola*:** Bone throwing, to diagnose an ill person
- ***go phekolwa/u thathuvhiwa*:** Diagnosis
- ***isi mgbaka/isi mmebi/agwu*:** When a person is suffering from this type of mental illness it is said that they are possessed
- ***lewa*:** The falling of bones during the diagnostic process
- ***molwetši/mulwadze*:** Patient
- ***moya wa badimo*:** Ancestral spirit
- ***muthi*:** Herbal medication
- ***nganga*:** Traditional health care practitioner
- ***tlhahlo ya semoya*:** Spiritual initiation
- ***ukufemba/nyakišiša*:** Smelling a person's problems or other issues
- ***ukuthwasa/kwetfwasa/gothwasa*:** An initiation process undertaken to become a traditional health care practitioner

Chapter 11

Same-sex intimate relationships and marriages among African indigenous people

Jeanette M. Sebaeng
School of Nursing,
Faculty of Health Sciences, University of the Free State,
Bloemfontein, South Africa

Seepaneng S. Moloko-Phiri
School of Nursing,
Faculty of Health Sciences, North-West University,
Mahikeng, South Africa

Ramadimetja S. Mogale
Department of Nursing Science,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Azwihangwisi H. Mavhandu-Mudzusi
Department of Health Studies,
College of Human Sciences, University of South Africa,
Pretoria, South Africa

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Abstract

Same-sex intimate relationships and marriages among indigenous people in Africa are viewed as un-African. In most African societies, sexuality is perceived as being exclusively heterosexual. One of the rationales for promoting heterosexuality as the preferred sexual orientation is reportedly to protect and preserve African culture and traditions. However, it should be noted that it was uncommon among African communities to talk about sexuality and sex-related matters as it is viewed as a taboo and a private matter. As a result, homosexuality in Africa is not adequately researched or spoken about. However, several studies have reported on same-sex intimate relationships and same-sex marriages within African societies. The purpose of this chapter is to discuss concerning views on homosexuality in Africa, the practices of same-sex relationships and marriages on the continent. The chapter also looks at spiritually driven same-sex relationships and culturally driven same-sex relationships. The chapter provides a brief discussion on the attitudes of African states towards people engaging in homosexuality, derogatory terms used against people involved in a same-sex intimate relationship, laws against homosexuality and discrimination towards LGBTQI+ (lesbian, gay, bisexual, transgender, queer, intersex and seeking) people in the health care system.

Sexuality and sex-related matters

The description of the term 'homosexuality' or the relationships among same-sex intimacy is lacking in the African people and among indigenous African people. Homosexuality in the Western context is defined as the acts of feeling and engaging in sexual intimate activity with a person of the same gender (Adejuwon 2020). People identifying as being homosexual include lesbian, gay, bisexual, transgender and queer persons, together referred as LGBTQI+. In this chapter, the terms homosexuality, same-sex intimacy and LGBTQI+ are used interchangeably.

Same-sex intimate relationships and marriages are viewed differently in Africa. While certain countries embrace homosexuality, it is difficult for most African countries to accept the practice. The negative attitudes towards homosexuality are based on the view that it is *un-African*. According to Du Pisani (2012), the term 'homosexual' does not originate in Africa, and it is a Western conception. As indicated, most African countries strongly believe that the practice of homosexuality is un-African (Giwa et al. 2020; Kheswa 2018; Masuku 2015; Wahab 2016). Msibi (2020) also argued that homosexuality does not originate in Africa and was conceived in the 19th century in the West. According to Okpadah (2020), homosexuality is immoral socio-cultural pollution influenced by Western culture.

One of the reasons same-sex relationships and marriages are viewed as being *un-African* is to protect heteronormativity. According to Moagi and

Mavhandu-Mudzusi (2021), heteronormativity is upheld to promote heterosexuality as the only normal, healthy and natural pattern of human behaviour. A family is a social institution that has been associated with certain general principles related to its composition, kinship patterns and authority patterns (Manyama 2017). A male and a female constitute a family within a marriage, and there is an expectation of an interpersonal relationship in which sexual intercourse is approved. This has led to many African people advocating for heterosexual marriages and not embracing homosexuality. The view held by African societies on same-sex relationships influences the way health care professionals interact with members of the LGBTQI+ community.

Although there is a notion that same-sex relationship is un-African, there are practices which indicate that same-sex relationships was/is practised in Africa. Certain cultural practices prove that same-sex relations were practised among the African indigenous people. Ebimboweni (2019) posited that the West is not responsible for homosexuality because the practice appears natural to some indigenous people on the continent. Within the indigenous African societies, several practices prove that same-sex relationships have always existed in Africa, and these include marriage between two females, same-sex intimacy between females and same-sex intimacy between males. The chapter also discusses same-sex relationships that are spiritually driven.

Same-sex marriages between females in Africa

Several studies have confirmed the existence of female-to-female marriages in Africa (Kareithi 2018; Maphalle 2017). These marriages occurred among different societies on the African continent. Most African cultures believe and promote the bearing of children as the central importance of marriages, and as such, alternative measures were always taken when the genealogy within the families was threatened. According to Kareithi (2018), another reason for female-to-female marriages was to enhance the kinship ties of either blood family or marriage. This is evident among the Igbo and the Ibibio people of Nigeria, where female-to-female marriages were approved when a married female could not bear children for her husband. The married female will therefore take the initiative to get her husband a younger female of childbearing age to bear children for the family (Maphalle 2017). The wife will therefore pay the bride price and continue to support the new bride and the children (Maphalle 2017). After birth, the children will assume the husband's name. This was also practised by the Kisii, the Nandi, the Kamba and the Kikuya in Kenya, where married females would identify young brides for their husbands (Akpan 2017; Ocholla et al. 2012). In all these cases, females pay the bride price, although there will not be any form of sexual intimacy between the females.

Other African countries practising same-sex marriages are Ghana and South Africa. In Ghana, this tradition was found among the Nankani people in the northern parts of the country (Amenga-Etego 2012). According to the author, female-to-female marriage within this tribe was used as the last desperate option after all other possible measures of bearing children failed. In other countries like South Africa, female-to-female marriages among African females occured in families where there are no male children in the family and not necessarily in marriage. Same-sex marriages between females in Africa were practised for different reasons and could easily be confused for same-sex where there are intimate relationships. A female would identify a potential bride for the family and would pay the bride price, and this is practised among the Bapedi and VhaVenḓa, where brides are married on behalf of the family. The practice is termed '*go nyala ngwetši ya lapa*' in Sepedi and '*u malela musadzi muta*', which translates to marrying a bride for the family (Mokotong & Monnye 2013). According to Mokotong and Monnye (2013), *go nyala ngwetši ya lapa* was practised as a way of saving or reviving a family name facing extinction. The '*go nyala ngwetši lapa*' was a cultural practice meant for the conservation and extension of the family, thus providing for an heir of the childless parent-in-law (Mokotong & Monnye 2013). Amenga-Etego (2012) stated that in instances where a female is married to a daughter of a specific family with the intention of 'resuscitating' her family lineage, the daughter remains a daughter despite playing the male role of providing for this family. Among the Lovedu people of South Africa, a married female in a childless relationship would pay a bride price for another female to bear children for her; however, the female would be allowed to discretely choose a sexual partner, and this male is regarded as a sperm donor with no rights whatsoever to any children born. The Nankani tradition in Ghana demands that elderly females or females whose sons are married, withdraw from sexual intercourse. In these instances, in order not to deny their husbands' sexual needs, females arranged for younger brides for their husbands (Amenga-Etego 2012).

Among African societies, there are gender roles that members are socialised into from childhood. There are therefore roles that are performed by or have been culturally assigned to males. As such, a female may marry another for an opportunity to be awarded a piece of land (Kareithi 2018). As females were not considered for land ownership, females had to therefore pay the bride price to be accepted and permitted to assume such roles.

Females-to-females marriages were also practised to foster freedom and independence, particularly in patrilineal-dominant societies (Karethei 2018). According to the same author, freedom and independence among females were enhanced in that the wife was able to freely choose her sexual partner without interference from the spouse. Furthermore, privacy was maintained by the wife by letting her have her own home separate from that of the female

partner, thus further guaranteeing freedom. This type of marriage was most significant for females who were in abusive marriages and were unable to leave because of not being in a position to pay back the bride price. Once the female is married to another female, the wife can issue a divorce against her husband and then use the bride's money to repay him (Karethei 2018).

Females-to-females marriages in African societies occurred in cases where old females were left alone. The older female marries a female into her family who can perform household duties which a person of her age can no longer perform (Maphalle 2017). The elderly female may identify a male within her family or allow the young married female to get herself a partner with whom she can procreate. The biological father will have no rights over the born children. According to Karethei (2018), same-sex marriages among African females were also considered for companionship. This was helpful, especially among elderly females who needed to be taken care of. Although the wife to the husband assisted with household chores and took care of her, their relationship was not that of a master-servant.

A female who marries another female should pay a dowry that makes her the social and legal father of the wife's children (Akpan 2017). As a result, the bride price automatically legitimises the marriage, and children born in this union belong to the person who paid the bride price (Maphalle 2017). Among Balobedu of the Bapedi in Limpopo, the queen within this kingdom was prohibited from marrying a male but encouraged to marry a female (Mkasi 2013). Bapedi then emphasises the ownership of the children by the saying '*ngwana ke wa dikgomo*' ['the child belongs to the one who paid the bride price']. The female who paid the *lobola* [bride price] has all the responsibilities, like those of a married male, such as the provision of shelter, clothes, food and finances to the family. The bride had to display respect and loyalty, cook, clean and take care of the household. In this instance, the choice of the sexual partner (male) could be made by either the bride or the partner (Maphalle 2017).

There are instances where same-sex marriages were forced because of circumstances, as in the case where the initially arranged marriage was heterosexual, but because of circumstances, the relationship ends in same-sex marriage. For example, among the VhaVenḓa, wherein marriages were arranged. The process of an arranged marriage occurs when a mother identifies a female that they deem as suitable for their son (Raphalalani & Musehane 2013). The mother will then make all the arrangements with the lady's family to pay *lobola* for her son, unbeknown to him. According to Raphalalani and Musehane (2013), it was believed among the VhaVenḓa that the wife belongs to the family. As *lobola* has been paid if the son is not interested in her, the mother will continue to take care of the female as her wife, and she becomes part of the family despite the son showing no interest. The female-to-female marriages discussed in this section imply that the marriages were without sexual intimacy and had varied purposes other than sexual gratification.

Same-sex intimacy between females in Africa

The previous section discussed same-sex marriages that were mainly female-to-female and were exclusively free from sexual intimacy. This section provides a discussion on which same-sex intimate relationships occur. Same-sex intimacy relationships in the context of this chapter refer to engagement in sexual activities aiming at sexually gratifying parties involved. The desire for same-sex intimate relationships in Africa was found to be in existence. However, Malawian society views homosexuality as an act rather than a sexual orientation (McNamara 2014).

According to McNamara (2014), the existence of same-sex intimate relationships is evident through the availability of cues among the Shona people of Zimbabwe, where members of the community have sexual desire for people of the same sex. Moreover, the author indicated that the Basotho in Lesotho allowed for marriages among Basotho females. Unlike the purposes mentioned in the previous section, the females in Lesotho would be engaged in rubbing, fondling and cunnilingus activities to satisfy the sexual needs of the members involved. According to Blackwood (2000), the intimate relationships between young and older females ('mummy-baby') in Lesotho started during initiation schools, whereby the older females were expected to guide the young ones. The intensity of the mummy-baby relationship in Lesotho reportedly ended in same-sex marriages (Blackwood 2000). In Mkasi (2013), it is highlighted that although same-sex relationships among females were displayed through touching, holding hands and kissing, signs of sexual expressions have always existed. Although this practice of same-sex intimacy is not documented in most African countries, the practice in Lesotho implies that Africans knew about this type of marriage before the invasion by the West.

Same-sex intimacy practices between males

Same-sex intimacy relationship was not only seen among females but was documented among males too. Although there is minimal documentation regarding same-sex relationships between males, there is evidence that these kinds of relationships were practised. Understanding the existence of same-sex intimate relationships among males is crucial for the health care sector as health care professionals will have knowledge of tackling issues such as reproductive health when required.

In Africa, sodomy between males was common among the Bangala of the Congo and was acceptable to the community (International Race Relations [2019] 2020). In addition, homosexuality was common among unmarried Tutsi and Hutu males in Rwanda (International Race Relations [2019] 2020). It is also argued that same-sex relationships used to be a common practice among the Nyakyusa males of Tanzania before marriage in the mid-1930s.

Subsequently, Ronald Louw published a paper on 'Same-Sex Desire and African Culture: Untraditional and Traditional Weddings in the 1950s in Durban, South Africa' (Amory 1997). Louw documented male-to-male marriages in a shanty town outside of Durban, where there was a vibrant 'homosexual' community and regular weddings were held. This gives credence to homosexuality in mines and prisons and complements the current research on the history of same-sex relations/intimacy. Similarly, Ibrahim (2015) reported that same-sex intimacy was accepted and often legally recognised in ancient Egypt. Furthermore, the same author asserted that, in the pre-colonial period, the Asante practised same-sex marriages where dowry was paid for boy-wives, whereas damages were paid for infidelity. In addition, Ibrahim (2015) argued that the Meru people of Kenya, the Bantu of Angola and the AmaZulu of South Africa allowed transgender males to marry; the effeminate males of Uganda were allowed to marry other males; and in Ethiopia, sexual minorities were considered 'God's' mistakes.

Same-sex relationships among Africans were also practised among the *Lovedu*, *Koni* and AmaZulu (Mkasi 2013). McNamara (2014) further outlined a Malawian idiom – '*cha motende*', which translates to mean 'to act like two Billy goats'. This saying was used to describe male-to-male sexual activity. Same-sex relationships among African males were also influenced by the industrial revolution, where African males had to work away from home as a way of providing for their families. Most males were employed in the mines and the employers, mine owners, provided males with accommodation (hostels) where females were not allowed. Dlamini (2006) discussed the mine compound boy-wives practice as males employed in the mines were not allowed to bring their females or wives to the mines. Therefore, this promulgated same-sex intimacy between males. Additionally, same-sex relationships were also found in the mine hostels through what was referred to as *mteto* (a same-sex marriage ceremony in which novices are married to veterans). According to Epprecht (2002), the Basotho males are said to have not been involved in male-to-male sexual intimacy until they joined the South African mines for employment. It is alleged that the Basotho males learned homosexual male practice from the mines, a practice that was referred to as *inkotshane*. Basotho males adopted the practice near to their language and referred to it as *bokonchana* (male-male sexual relationships). However, an interview with some of the participants in a study conducted in Lesotho found that same-sex intimacy relationships were practised, and one participant indicated it being performed among males between the thighs (Epprecht 2002). However, this practice did not include oral and anal sex.

Spiritually driven same-sex relationships

In Africa, traditional health care practitioners bear different names according to the different ethnic groups and cultures to which they belong.

Moreover, traditional healers possess different roles and powers in the healing process depending on an individual's gift from their ancestors. Traditional healers are respected members of society and are the custodians of the indigenous culture according to the people they serve. However, while the African communities believe in heterosexuals and are in support of such relationships, it is well-known that there are traditional healers who engage in same-sex relationships. Although this is the case, these practitioners continue to practise and render services to the same communities who perceive same-sex relationships as a taboo that does not represent African morals and values. The involvement in same-sex relationships, particularly among the *sangomas* (traditional healers), is justified. According to Mnyadi (2018), sangomas' bodies may be possessed by the spirits of the ancestral males dominating as their guides, thus influencing their sexual identity. For instance, a sangoma who is influenced by a female spirit may be interested in both females and males (Mkasi 2013). In these instances, homosexual orientation and transgender identities are not necessarily considered offensive to society but rather respected attributes (Nyoni 2020). Sangomas involved in same-sex relationships are believed to be influenced by the spirit of their ancestors and are not subjected to societal prejudice (Kaunda 2015). Conversely, members of the sangoma community may not tolerate the involvement in same-sex relationships. For instance, a member of the sangoma community was shouted at and encouraged to hide her sexuality as her practice was un-African (Nkabinde 2008). After opening up and displaying her sexuality publicly, Nkunzi, a Zulu sangoma, was reprimanded by elders for her uncultured behaviour (Nkabinde 2008). The existence of gay and lesbian sangomas was evidenced by a formation of a group called Sangomas Coming Out in Gauteng (Nkabinde 2008). The practice of same-sex relationships among traditional healers, particularly sangomas, was also documented (Morgan & Reid 2003). In the study, gender identity was held by the sangomas whereby terms such as a *skesana* (a term used to describe a feminine partner) and *injonga* (a term describing a male) were identified. Interestingly, some of the sangomas interviewed in Morgan and Reid's study were confident in confirming their same-sex relationships. A member may also be possessed by both male and female ancestors, thus leading to an individual being bisexual.

Another practice among the AmaZulu is that for the male sangoma to be powerful, they should use *muthi* that is mixed with semen. For the *muthi* to remain effective, a male is not allowed to be intimate with his wife or other females. According to Kaunda (2015), in Zambia, there was a prophet (male) who dressed like a female and plaited baskets as a female, and the male was said to be sleeping among but not with females. Mkasi (2016) concluded that same-sex relations among traditional healers are indigenous and are not influenced by Western paradigms.

Culturally driven same-sex relationships

Sexual socialisation is a lifelong process through which individuals learn about sex and sexuality (Foust et al. 2020). In most African countries, special sex education sessions for both young boys and girls have been performed in secluded areas away from their homes during initiation or circumcision. The duration and process varied from country to country and culture to culture. Traces of same-sex relationships were also noticed during traditional ceremonies in Zambia (Kaunda 2015). Like in other African cultures, the Ndembu in Zambia practised the rite of passage through a ceremony called *Mukanda*. The Mukanda ceremony was regarded as sacred, and the main goal was to cleanse the boys (Kaunda 2015). During the Mukanda ceremony, the initiates were removed from the normal social structure and isolated in the bush for a specific period (Kaunda 2015). The boys will be with their teachers, usually elderly males. The males would be forbidden from having any sexual activity with their wives and should stay with the boys (the initiates). As a result, their sexual needs could not be met for most of the circumcision period. One of the processes during the initiation period was for the *anyadi*, where initiates put on clothes when they were expected to play sexual intercourse with the genitals of the elderly males, and they were made to believe that the act would lead to quicker healing for their circumcised penises. Kaunda (2015) further indicated that during the initiation period, initiates would be expected to have sexual intercourse with one another to demonstrate to the elders how they will have sex with females. This was considered part of the sex education preparing them for the rite of passage to manhood. However, it should be noted that the initiates were given a chance to consent or not to such activities to protect them against rape. As initiation practices were kept secret, these activities were never spoken about.

On the contrary, the practice of the ritual of rite of passage from boyhood to manhood among AmaXhosa in South Africa has been a practice for centuries (Ntozini & Ngqangweni 2016). The process of initiation into manhood for this tribe is known as *ulwaluko*, performed by *abakhwetha*, who are the initiates. Growing up in cultural socialisation where *ulwaluko* was viewed significantly to be recognised as a male. There is also a belief that *ulwaluko* is sacred and is a cultural practice of introducing an individual to their ancestors. It is assumed that those participating in the ritual are heterosexual and therefore display masculine behaviour and will take part in the marriages and fathering of children (Ntozini & Ngqangweni 2016). Parents with gay sons could identify their behaviours, and they will still take their children to *ulwaluko* with the hope that the ritual process will root out the homosexual behaviours and convert them into 'proper males' (Mashabane & Henderson 2020; Ntozini & Ngqangweni 2016).

Attitudes of Africans towards same-sex relationship practices and marriages

The view that homosexuality is *un-African* influences how people who practice it are perceived and treated. The treatment includes the use of derogatory names and laws against homosexuality. As a result, there are no existing terms to describe people in a same-sex intimate relationship in most African languages. Conversely, people belonging to this group are subjected to varied discrimination and prejudices within their communities, with different descriptions used to humiliate them. It is normal for citizens to use these terms to degrade, discriminate, shame and undermine the dignity of LGBTQI+ people.

A common prejudice among the LGBTQI+ community is the descriptive terms used to distinguish them from heterosexuals (Brown 2017). The descriptive terms vary from country to country, culture and language. In Namibia, gay males are referred to as *moffies* (Brown 2017). Similarly, the term *moffie* is also used among the Afrikaans-speaking community in South Africa (Du Pisani 2012). Another common term among Afrikaans-speaking people in South Africa is *trassies*, while they are called *isitabane/inkwili/ungqingili* among Nguni speakers (Fhumulani & Mukwevho 2018). On the contrary, an act whereby a male engages in sexual intercourse with another male is known as *matanyola* (Reddy 2013). Moreover, a masculine gay male is referred to as *injonga*, while a feminine male is referred to as *skesana* in South Africa (Reid 2003). In Zimbabwe, the Shona people use the word *chingochani* to describe homosexuality (Shoko 2010).

The level of unacceptability of the practice is further accentuated through the expression of views on the practice by several leaders in the African continent. For instance, Presidents Sam Nujoma of Namibia and Robert Mugabe of Zimbabwe viewed LGBTQI+ community members as being social misfits who were not fit to live (Okpadah 2020). President Robert Mugabe was further quoted as saying people having non-straight sexual orientation degrade human dignity and behave worse than pigs and dogs (Okpadah 2020). To indicate his non-acceptance of homosexuality, President Robert Mugabe further expressed his thoughts by saying 'let the Americans keep their sodomy, bestiality, stupid and foolish ways to themselves, out of Zimbabwe. Let them be gay in the US, Europe and elsewhere' (Essien & Aderinto 2009).

The discussions around and about sexuality in most African states were not only viewed as secret and sacred but also evil (Shoko 2010), thus hindering a deeper understanding of the matter. For example, there is strong evidence that African males and females are often persecuted based on their sexual practices or orientation (Amory 1997). The author further reported that the

International Gay and Lesbian Human Rights reported the rape of four lesbians who sort refuge at the feminist centre in Calabar, Nigeria, in 1994. In another turn of events, while doing fieldwork in Tanzania, the author overheard a friend laughing and saying there was a male who was severely beaten for just being a *shoga* (homosexual). The negative attitudes towards homosexuality lead to homophobia and abuse of the members of the LGBTQI+ community.

Laws against homosexuality

Certain African leaders believe that recognising the rights of LGBTQI+ persons in Africa is another form of cultural infiltration and imperialism (Nyoni 2020). The rejection of same-sex relationships or involvement in the LGBTQI+ community in Africa is strongly denied, as evident in the legislature that criminalises the practice. According to Nyoni (2020), 50% of African countries still criminalise same-sex acts between two consenting adults. Examples of these are enacted pieces of legislation by African countries that criminalise LGBTQI+, including the 'Kill the Gays bill' in Uganda (Amusan, Saka & Adekeye 2019), which is currently known as the *Anti-Homosexuality Act 2014* (Moagi & Mavhandu-Mudzusi 2015). The *Criminal Code Act of 1916* and *Same-Sex Marriage Prohibition Act* (SSMPA) are some examples of anti-homosexuality Acts passed in Nigeria (Igwenyi, Eni & Udu 2020). The SSMPA barred same-sex relationships and unions, cohabitation between same-sex partners, as well as the prohibition of groups, organisations and clubs for the LGBTQI+ community (Giwa et al. 2020). The punishment for those involved ranges from flogging to life imprisonment and is stipulated in legislation in some African countries (Giwa et al. 2020). Tanzania is one of the countries where lesbian and gay relations are not acceptable as they are considered immoral, unacceptable and illegal (Manyama 2017). In Namibia, legislation that criminalises same-sex conduct is still upheld and describes sexual acts between males as sodomy (Brown 2017). Therefore, individuals practising male-to-male intimate relationships may feel unsafe, insecure and unprotected by the law.

Discrimination in the health care system

Essential health care workers in Africa are socialised in the culture into which they are born. What they learn within their community about the LGBTQI+ community might be contrary to what they learn in practice. As such, some end up taking up those beliefs in their workplace. Mkhize and Maharaj (2020) asserted that LGBTQI+ persons are more likely to experience an array of health care inequities, increasing their risk of sexually transmitted infections (STIs) and HIV. The perception of African sexuality as being entirely heterosexual has led to some health care practitioners disregarding the reproductive health care service needs of the LGBTQI+ community. The behaviour is evidenced by this excerpt:

> [*W*]hen I got into the consultation room, I explained to a nurse that I needed contraceptives, a doctor had referred me because of my abnormal menstrual periods, but the nurse refused to give me contraceptives, no matter how hard I tried to explain that I am not sleeping with males and I need them for abnormal periods. A nurse said I am a lesbian and I don't need contraceptives and she did not give them to me. (Cele, Sibiya & Skhela 2015, p. 10)

Moreover, the education and training of health care professionals exclude health issues of the LGBTQI+ community, thus lacking awareness and their management. To this day, most African countries continue to lag in providing care for LGBTQI+ (Mkhize & Maharaj 2020). Chapter 2, sub-sections 9(3) and 27(a) of the *Constitution of South Africa Act 108 of 1996* states that no one should be discriminated against directly or indirectly on one or more grounds, including race, gender and sexual orientation, and all have the right to health care. Even though this is the case, LBGTQI+ issues remain controversial in Africa.

Recommendations

The view that homosexuality is un-African is not helpful but an obstacle to digging deeper into the phenomenon to have much insight. This chapter is therefore making the following recommendations:

- Community dialogues about sexual intimacy and homosexuality. Indigenous elderly must ensure that these issues are included as it will help members to understand the issues, thus creating an opportunity for clarity and preventing the misconceptions that may prevail.
- Awareness-raising platforms for African indigenous communities, particularly on the biological functioning of the hormones and their effects on how individuals respond and behave sexually.
- The education and training of health care professionals to include courses on homosexuality and LGBTQI+ to empower them in providing quality care to those belonging to this community.
- Education and awareness to governmental authorities and lawmakers. This will enable them that understand homosexuality its beliefs, values and norms in certain cultures.

Conclusion

This chapter presented same-sex marriages and same-sex intimacy relationships taking place in the African context among indigenous people. The discussions revealed the existence of same-sex marriages between females and females and highlighted how such marriages did not involve intimacy but were performed for varied relatable reasons and societal demands. Female-to-female marriages were/are seen to be culturally acceptable as the motive was/is beneficial to the family structure and community. The chapter also highlighted

the existence of same-sex intimate relationships between female and female and male and male. However, such relationships are mainly accepted if they are spiritually driven. The notion that same-sex relationships are *un-African* could not be concluded in this chapter. Homosexuality or same-sex relationships are hardly spoken about in most African societies, but there is an existing affirmation that it is not permissible and violates the stipulated regulations, beliefs and values of citizens (Kaluba 2015).

Glossary

- ***bokonchana*:** Male-to-male sexual relationships
- ***abakhwetha*:** Initiates
- ***cha motende*:** Male-to-male sexual activity
- ***chingochani*:** Homosexuality
- ***go nyalela lapa mosadi*:** Marrying a bride for the family
- ***injonga*:** Male-to-male sexual relationships or gay males
- ***inkotshane/bokonchana*:** Male-to-male sexual relationships
- ***inkwili/ungqingili/isitabane/trassie/moffie*:** A gay male
- ***lobola*:** Bride price
- ***matanyola*:** A male engaging in sexual intercourse with another male
- ***mteto*:** A same-sex marriage ceremony
- ***ngwana ke wa dikgomo*:** 'The child belongs to the one who paid the bride price'
- ***ngwetši ya lapa*:** A female married to another female as a family bride
- ***shoga*:** Homosexual
- ***skesana*:** Female-to-female sexual relationships
- ***ulwaluko*:** The process of initiation into manhood
- ***u malela musadzi muta*:** Marrying a bride for the family

Chapter 12

The role of patriarchy and its influences on domestic violence against females and children in Africa: An indigenous perspective

Nombulelo V. Sepeng
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Seepaneng S. Moloko-Phiri
School of Nursing,
Faculty of Health Sciences, North-West University,
Mahikeng, South Africa

Fhumulani M. Mulaudzi
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Abstract

African people do not have a common name for domestic violence against females and children because the term 'domestic violence' has colonial connotations. Before colonialism, Swahili referred to domestic violence as

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'*unyanyasaji wa nyumbani*', which means violent or aggressive behaviour in the home, most commonly involving the violent abuse of a spouse or partner. Despite this, domestic violence against females and children in Africa is prevalent, and this is because African societies are patriarchal and still look at the role identification of males, females and children differently. The patriarchal societies used harmful practices from time immemorial, as depicted by gender roles, customs and language use. The proverbs and idioms defended as cultural traditions predispose females and children to domestic violence. In an attempt to deal with this problem, mechanisms such as the introduction of human rights and awareness were put in place to address gender equity to address violence against females and children. However, to date in Africa, domestic violence against females and children remains a public health care concern that needs urgent health care interventions. Although patriarchal, African societies had their indigenous measures to deal with violence against females and children; however, these are not well-documented in the literature. This information is needed to educate health care practitioners about traditional indigenous measures that can be utilised to prevent and promote holistic care among African females and children experiencing domestic violence.

Patriarchy and violence

The term 'domestic violence' did not exist in most African societies, as females and children were expected to be obedient to the rules set by the head of the family. Irrespective of this, Mba (2014) explained that in Africa, the word 'domestic violence' does not have a similar connotation as it does in the west. However, in the current era, African people use their languages to directly translate concepts that are topical and pertain to their experiences. For example, 'domestic violence' is translated as '*luhlukumezeko olumasikizi e lwa bafazi na bantwana*' in isiXhosa, '*thesebediso e fosahetseng ya basadi le bana*' in Sesotho and as '*ilokulo in Yoruba*'. Hence, we have adopted and used domestic violence as the central word to describe females and children abuse that happens in the home.

Incidences of domestic violence against females and children are a public health care problem worldwide, with higher rates reported in Africa. In support, Luck (2016) indicated that about 51% of females in Africa have experienced domestic violence because they are living in a patriarchal society that still prioritises the needs of males over those of females and children. Prioritising the needs of males perpetuates gender inequity. The traditional gender roles and patriarchal values are passed from generation to generation (Nkama 2019; Nkosi 2011; Okafor, Akinwale & Doyin-Hassan 2007). According to Better Care Network (2017), approximately half of all African children aged two to seventeen years old have experienced violence under the guise of being disciplined by their fathers.

Currently, females and children report different types of domestic violence resulting from patriarchy. The different types of domestic violence against females and children include physical, sexual, psychological and emotional abuse (Moore 2008; WHO 2013). It is reported that these forms of domestic violence against females and children predispose them to long-term mental health, psychosocial and physical health problems (Gill et al. 2008; Sepeng & Makhado 2018; Woollett, Bandeira & Hatcher 2020). However, the risk factors associated with domestic violence were/are often not reported as African people viewed them as part of domestic issues that must be solved within the family through dialogue and consensus.

Historically, Africans used indigenous measures to address patriarchy and its effects on domestic violence against females and children. The use of proverbs and idioms, circumcision as a rite of passage, dialogues, the use of tribal and social courts, and the importance of traditional music were among the indigenous methods used to address the role of patriarchy and its influences on domestic violence against females and children. Therefore, in this chapter, the role and influences of patriarchy on domestic violence against females and children are addressed.

The role of patriarchy and its influences on domestic violence against females and children

Gender-based socialisation on domestic violence against females and children

The patriarchal system starts from birth, whereby the male child was prioritised and favoured more than the female child because African people believed that the male child would continue the family name. Therefore, the male child was born with authority over the female child. This favouritism for a boy child resulted in respect being accorded to females who gave birth to male children as compared to those who gave birth to female children or who were childless (Orisaremi & Alubo 2012). On the contrary, African societies expected males to provide for families (Clowes, Ratele & Shefer 2013). However, in the current era, roles are often reversed because females are working, and at times, they earn more than males. Therefore, in those situations, males mostly feel that they have lost their power and exercise it by venting out their anger on females, which can be shown through physical, emotional or sexual violence against the female.

Also, the socialisation of males and females to traditional norms and customs plays a significant role in perpetuating violence against females and children in Africa. Some of the traditional norms and social customs favour males. For example, males are expected to be forceful and less fearful than

females (Bhanot & Senn 2007). Alarbeed and Alhakim (2013) stated that accentuating these values shows the patriarchal impression where a male's expression is the law that females and children are obliged to obey, irrespective of their judgement. Practices like males not crying, which show that they are hurt, are classified as a sign of weakness. Not sharing their feelings affects their emotional health, which predisposes them to suffer from depression and take their frustrations on females and children (Starkowitz 2014).

A study conducted in Ghana revealed that males are using violence to control females and to emphasise their authority and supremacy (Sikweyiya et al. 2020). In studies by Sikweyiya et al. (2020); Lau et al. (2006); Cousins (2001), males stated that they could sleep with females as they desire, regardless of their consent to have sex or not. Additionally, married males would beat their wives as a way of disciplining them (Cousins 2001; Lau et al. 2006; Sikweyiya et al. 2020). Despite that, some females don't see any issue when beaten by their husbands and having non-consensual sexual intercourse with their spouses because they consider sex as part of their husband's conjugal rights (Cousins 2001). Hence, to date, marital rape is still not accepted among African people. These risk factors resulting from patriarchal-dominant societies must be documented to make health care professionals aware so that they can establish strategies on how to educate and create awareness about gender-based socialisation that is affecting the health of females and children. For example, health care professionals must educate females and children to avoid stereotypical behaviours, downplaying, being in denial and accepting physical or sexual violence as part of disciplinary measures that should be used against them. When females and children have this knowledge, they will be able to differentiate between unacceptable and acceptable morals and behaviours.

Additionally, the practice of circumcision, known as *ulwaluko* in isiXhosa, can be used to socialise young males on how to avoid perpetuating violence against females and children. More details regarding circumcision as the rite of passage are described in Chapter 4. However, there is secrecy in the practices of *ulwaluko*; the other intention of this ritual was to teach young males not to wield or use male power or supremacy to oppress or abuse females and children (Matobo, Makatsa & Obioha 2009). The purpose of *ulwaluko* is to malestor young males about African culture, which inculcates the principles of *ubuntu*, self-respect and valuing, respecting and cherishing others (Matobo et al. 2009; Siswana 2016). *Ubuntu* emphasises the restitution of harmony. During circumcision, these young males are taught how to live in harmony with other people. Domestic violence against females and children contradicts *ubuntu* teachings of living in harmony with others. Mentoring principles and values, such as instilling *ubuntu* in initiates, could play an important role in preventing domestic violence against females and children in African communities.

In African societies, exclusion is used as a form of punishment in cases where an individual fails to uphold the cultural principles of respecting himself

or others. The exclusion was done by following the processes of taboos. Although they appear strict, threatening and intimidating, their main purpose was/is to have a community that was obedient and respected values (Mutungi 2019). Additionally, taboos were used to teach others the consequences they would face in case they harmed others (Dosu 2017; Mutungi 2019; Omobola 2013). For example, taboos such as driving perpetrators of sexual violence out of the village were done to protect females and children against domestic violence. Additionally, communities will go to the extent of giving the perpetrator of violence against females and children names to ridicule them because of failing to adhere to the cultural principles set. As a result, health care professionals should be knowledgeable about *ulwaluko*'s positive practices to reinforce them among teenage boys who have undergone circumcision. The reinforcement is necessary to prevent gender-based violence against females and children. Another thing is health care professionals should be educated on *ubuntu* principles so that they can impart the knowledge to the communities they serve. Health care professionals can also teach the young males who opted to go for circumcision at the hospital about the positive practices of *ulwaluko* and the consequences of perpetrating violence against females and children.

Gender-based African proverbs and idioms on domestic violence against females and children

Proverbs and idioms are important in African cultures all over the continent (Olasupo, Kikelomo & Adeniran 2012). According to Olasupo et al. (2012), these proverbs can be used to describe different roles between males and females; however, they prioritise the needs of males over those of females. Furthermore, Chiliza and Masuku (2020) claimed that some proverbs perpetuate gender inequalities. Africans generally believed that females could not perform certain tasks because they were considered males's roles. For example, there is an Igbo proverb '*nwaàny s nà ya nà nwok hà ya ny lie mamr el*', which means 'if a female claims equality with a male, let her urinate upwards' (Balogun 2010; Mmadike 2014). This proverb is used to oppress females by emphasising males's dominance over them, even though female's anatomical structures do not allow them to urinate like males (Balogun 2010; Mmadike 2014). Such proverbs depict that according to the culture, males and females can never be considered equals. Females today face physical, medical and mental health consequences as a result of patriarchal dominance and influence. According to Mpungose (2010), proverbs were originally used only by males and grandfathers because it was considered impolite for females and children to use them in their conversation unless the use was approved by males.

Moloko-Phiri, Mulaudzi and Heyns (2016) examined female's experiences of domestic violence resulting from the use of proverbs. In the study, Moloko-Phiri et al. (2016) cited several proverbs which encourage males to

abuse females. For example, they have explored the proverb '*lebitla la mosadi ke bogadi*', which entails that the female's grave is by her in-laws. The connotation of this proverb is gender-biased because it is mentioned nowhere that males must also endure the hardships of a marriage that is not working. To further prove that some of the proverbs are gender-biased, Moloko-Phiri et al. (2016) cited the proverb: '*monna ke tshwene o ja ka matsogo a mabedi*', which entails that a male is like a monkey, eating with both hands. The reflection of this proverb states that married males are permitted to have concubines to satisfy their sexual needs. These practices negatively impact females's health.

On the contrary, proverbs and idioms served as a pedagogical strategy to promote resilience and coping strategies among females and children. For instance, Mutingi (2019) stated that proverbs were used to teach about patience, hope, rational choice, honesty and prudence, which serve as an intervention in traumatic situations. Furthermore, '*lebitla la mosadi ke bogadi*' was a positive reinforcement that gave females hope to remain committed to their marriages despite the challenges (Moloko-Phiri et al. 2016). In the study, some of the females stated that they found the proverb to be an aid in keeping them positive in their behaviour and thinking, which strengthened their marriages, and they vowed to use it in the future (Moloko-Phiri 2015). Another such proverb is '*obusasi tibunisa'mara*', meaning pain does not kill (Mutingi 2019). According to Mutingi (2019), the proverb *obusasi tibunisa'mara* was also used to comfort people facing painful situations, to assure them that it will not last.

Situations come and go, and therefore people should not lose hope. In this instance, health care professionals should teach African females and children facing domestic violence about the negative consequences which can result from the use of such proverbs. However, they can also use proverbs as their coping strategies to overcome mental health effects resulting from the experiences of domestic violence.

The traditional practice of joining the newlywed couple

One of the strategies that should be used to prevent domestic violence against females and children in Africa is to join or make a sacrifice for newly married couples. These newlyweds are joined by slaughtering an animal, such as a goat or a sheep. Afterwards, the elders will cook the meat and allow the couple to eat the same dish. This practice was done because of the belief that if the male and the female cannot share food in the same dish, they can never have peace in their marriage (Kenyatta 2015). Whenever there is no peace, people are subjected to fighting with one another and females are, in most cases, the ones that are exposed to physical violence. Tenkorang et al. (2013) indicated

that most married females in Ghana face various forms of violence as a result of patriarchal beliefs. When females are subjected to physical violence, they will be subjected to suffer from health-related consequences that may affect their physical, emotional and mental well-being.

Also, domestic fights expose children to violent behaviours. At times, the fights between parents socialise children into acts of violence, and they tend to think that is how life should be between married people. If there is a male child within the family, he will think that is how females should be treated in marriages. The girl might think females should endure violence in their marriages. According to the social learning theory, 'children learn through direct behavioural conditioning and by imitating the behaviour they have observed or seen reinforced in others' (Stith et al. 2000). Therefore, these practices must be known by health care professionals to educate African people about good practices which can be used to prevent domestic violence against females and children. Also, educating African people that their behaviour demonstrated to children serves as intergenerational transmission to learning. When children are raised within a peaceful and respectful family, they will be able to uphold those principles in their lives, thus preventing domestic violence against females and children.

The importance of traditional music on domestic violence against females and children

Traditional music is one of the cultural strategies to enhance coping strategies for domestic violence against females and children in Africa. Gunnestad (2006) stated that different cultures in Africa use diverse methods to generate resilience. For instance, when females get married in African countries, they sing songs that can assist them in generating resilience in how to handle their husbands when there are disputes. As the songs are popular in most African communities, health care professionals should teach females and children about the importance of the message that these songs convey to build their resilience when marrying into Africa's patriarchal system. Monteiro and Wall (2011) reported that the rituals involving dance play a significant role in dismissing and handling symptoms of psychosomatic distress and counteracting and reducing the influence of psychological trauma (Monteiro & Wall 2011). Music is therapeutic management that can be used to deal with the effects of violence. According to De Tord and Bräuninger (2015), when people dance, they move their bodies, which is regarded as a therapeutic tool to promote the integration of individuals' emotional, cognitive, physical and social well-being. Therefore, health care professionals must be equipped with this knowledge to use as strategies to boost the resilience of females when they prepare for the union of marriage and to manage the ordeal associated with domestic violence.

The importance of staying with extended families on domestic violence against females and children

Although the literature has documented that staying with extended families has predisposed females to violence, this method also served as an intervention to protect females against violence. In Africa, married couples used to stay with their extended families. This practice prevented issues related to intimate partner violence (IPV), which is also common in most African countries. Hatcher et al. (2013) indicated that family members in Kenya had managed IPV among couples who used to live with their in-laws. Fidan and Bui (2016) stated that crime rates are influenced by strong neighbouring relationships, meaning that it is easier to manage violence among couples that live with or in the same area as their extended families. Females who experience physical violence from their partners would visit their parents as a method of protecting themselves against domestic violence (Hatcher et al. 2013; Ward et al. 2012). Therefore, health care professionals must have this knowledge to assess whether the couple lives with the in-laws or not and to educate them about the available support structures that they can use to prevent domestic violence and associated factors affecting their health and well-being. For those living far away from their families, health care professionals can educate them about the importance of neighbourhood support structures to prevent issues related to domestic violence.

Dialogue between family members on domestic violence against females and children

Dialogue can be used to resolve conflict among couples whenever there is a dispute. In Africa, this method is commonly used, whereby the family head or uncles and aunts will convene a meeting with the couple to discuss the dispute and settle the cause of the quarrels at home (Maluleke & Nadar 2002; Maundeni, Ntshwarang & Mupedziswa 2018). Whenever there is a meeting, the aggrieved partner would present their case in front of the elders, who would counsel the couple for reconciliation (Rwenzori Forum for Peace and Justice 2007). This practice was favoured in ancient times because parents had authority over the children/juniors and they were respected, and it was easier for them to exercise their corrective powers (Fidan & Bui 2016). In other instances where females were disrespectful, they were reminded to be submissive, humble themselves and respect their husbands, who were regarded as the heads of their families (Sapkota et al. 2016). However, health care professionals must teach the community that reprimanding disrespectful females must be done carefully to avoid predisposing them to violence. Instead, health care professionals must teach them that the counselling committee must investigate the merits of each case by hearing both sides of the story to deal with the issue holistically.

The importance of tribal and social courts on domestic violence against females and children

African traditions always teach that females and children should never be molested or assaulted (Afisi 2009). This is because the king, chief and the community leader of the village were also regarded as African religious leaders or as the gatekeepers of the community; therefore, they were challenged not to turn a blind eye to issues of violence (Okyere-Manu 2015). They were also involved because African people had village courts that dealt with civil cases (Maluleke & Nadar 2002). The African religious leader's role and responsibility in those courts were to educate people about their culture and belief systems, which discouraged violence in their communities (Ushe 2015). The other role of the African religious leader was to enhance self-understanding sensibly and expressively to give an assurance of a healthy relationship between males and females (Ushe 2015). Religious leaders could carry out their roles and responsibilities because they loved their communities and had mutual respect among themselves, and they used traditional values and moral approaches that involved communication and dialogue purposefully to eliminate violence in their communities (Ushe 2015). This indicated that any religious leader or tradition that promoted injustice or violence against females was deemed intolerable and was condemned in all forms as delinquent (Ushe 2015).

The chief's or king's involvement was to settle disputes and promote mutual respect and peace. When there was a dispute between couples, the chief or the king of the village would involve their elders to establish if they had tried to resolve the dispute before the matter was escalated to them (Abeya, Afework & Yalew 2012; Afisi 2009; Rwenzori Forum for Peace and Justice 2007). In addition, their presence was to bear witness when the judgement was passed. As a result, when a couple disagrees within their family, it is still necessary to involve the parents and the chief. Their involvement during a dispute between a couple can promote fair decision-making because they will be able to investigate the merits of the case without perpetuating violence against females and children. Based on this, there is a need for health care professionals to be educated on the importance of involving the parents, elders, community leaders and the chief so that they can teach females about the available strategies that they can use whenever they have a dispute with their partners, thereby preventing domestic violence in their communities

Recommendations

The information on the prevalence and role of patriarchy, as well as its influences on domestic violence against females and children, will help health care

professionals in health care to educate the community about indigenous domestic violence prevention methods. For example, they can teach young boys that violence against females and children is not tolerated among Africans. Furthermore, health care professionals should teach young males how to apply cultural preventive and promotional measures taught during the circumcision on the mountain, such as using *ubuntu* principles to live in harmony with others to prevent violence against females and children in Africa.

Females must also be taught to avoid downplaying and accepting inappropriate behaviours that predispose them to violence. For instance, believing that a male beating them is a sign of love. To protect themselves from this ordeal, young females must be taught to report any form of domestic violence to their parents and religious leaders.

In addition, health care professionals must educate females and children about the causes of domestic violence and the treatment options available to females and children who have been exposed to it. For example, if they have been subjected to domestic violence, they can use proverbs and traditional songs to build resilience. However, practices that contribute to females's oppression and promote patriarchy should be exposed and strongly discouraged or modified for gender-sensitive purposes. There is a need to integrate modern indigenous methods for the prevention and management of domestic violence available to females and children in a western-dominated society.

Conclusion

This chapter provided the role of patriarchy and its influences on domestic violence against females and children in many communities on the African continent. Mostly, the literature documented the negative influences of traditional customs, beliefs and practices on domestic violence against females and children without providing the solutions that should be used by health care professionals when confronted with such situations. In this chapter, we have documented both the positive and the negative influences of traditional customs, beliefs and practices on domestic violence against females and children. Also, we have provided information on how these positive practices could be applied and used by health care practitioners to assist how African males should be socialised to avoid perpetuating violence against females and children and also how females and children should be treated for their well-being and to prevent the effects of violence against them. Most importantly, health care education must be given to females and children on how to recognise the signs of abuse and when to report and seek help when exposed to violence.

Glossary

- ***lebitla la mosadi ke bogadi*:** A Tswana proverb that means 'a male is like a monkey; he eats with two hands', implying that married males are allowed to have concubines to satisfy their sexual needs.
- ***luhlukumezeko olumasikizi* (Nguni tribe), *thesebediso e fosahetseng* (Basotho tribe) and *Ilokulo* (Yoruba tribe):** Direct translations for 'domestic violence'.
- ***mmonna ke tshwene o ja ka matsogo a mabedi*:** Another Tswana proverb that means a 'male is like a monkey; he eats with both hands', denoting that married males may have concubines to satisfy their sexual needs.
- ***obusasi tibunisa'mara*:** An African proverb that translates as 'pain does not kill'.

Chapter 13

Nutritious edible indigenous vegetables

Lindelani F. Mushaphi
Department of Nutrition,
Faculty of Health Sciences, University of Venda,
Thohoyandou, South Africa

Madimetja Magoro
Tompi Seleka College of Agriculture,
Agriculture Extension, Economics and Partnerships,
Marble Hall, South Africa

Phumudzo Tshiambara
Department of Human Nutrition,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Abstract

This chapter outlines the value of nutritious or edible indigenous vegetables. The utilisation of indigenous vegetables has been practised since time immemorial. Nutritious indigenous vegetables are usually categorised according to the portion of the plant that is eaten, such as leaves, stems, roots, tubers, bulbs and flowers. There are commonly consumed edible indigenous vegetables that embody nutritional values and medicinal properties, such as *thepe/Amaranthus*, *leroto/Cleome gynandra*, *dinawa/cowpea*, *thelele/Corchorus tridens*, *Solanum nigrum*, and *blackjack* and *monyaku/Momordica balsamina*. The purpose of this chapter is to shed light on the nutrition and medicinal values of nutritious or edible indigenous

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vegetables, including the preparation, preservation and storage of these indigenous vegetables. These edible indigenous vegetables grow spontaneously in the wild/field or farmland and thrive well under rain-fed conditions and adapt well to harsh environments. They are non-toxic food that indigenously is of great value to overall human health care. They are widely used in sub-Saharan Africa, especially in South Africa, as a relish and medicine; however, different indigenous cultures use them differently and for different purposes, practices and rituals. Cultural beliefs and practices necessitated the identification, utilisation and preservation of these indigenous vegetables. The health care benefit of these indigenous vegetables should not be assessed from the western premise but from African principles. South Africa should allow functional foods and nutraceuticals to be used as part of human diets and medicines. Indigenous knowledge should be preserved to address health care and nutrition challenges in South Africa.

Nutrition

In South Africa and sub-Saharan Africa, diverse rural communities have used indigenous vegetables for many years as a relish. Indigenous vegetables widely grow in the wild and are used by local communities as a relish or medicine. South Africa is rich, with a wide variety of biodiversity among indigenous leafy vegetable species with remarkable nutritious qualities such as macronutrients and micronutrients. These vegetables can be grouped into roots, leafy and tubers. One needs to understand the origin of the vegetables, as well as their nutritional and medicinal values.

In rural areas, these vegetables are fully utilised to address the food needs of households. Indigenous vegetables thrive well under rain-fed conditions and adapt well to harsh environments. The wild species differ in terms of shape, colour, growth size, etc. Rural communities during the 18th, 19th, 20th and 21st centuries used different wild vegetable species in their day-to-day food preparations. The consumption of these wild crops provided the consumers with the required calories and improved health status.

Africa is rich in the diversity of indigenous edible species. Indigenous vegetables are great sources of macronutrients and micronutrients. In most of Africa, indigenous vegetables are rich sources of nutrients such as vitamins and minerals. According to Willis (2006), South Africa is considered one of the most biologically diverse countries in the world as it has different species, ecosystems and rates of endemism. Most of the indigenous vegetables are found in the veld or farmlands, fallow or abandoned farmlands, while others are found in natural forests (Ruffo, Birnie & Tengnas 2002). The leafy vegetables are consumed with staple foods as a relish. South Africans refer to leafy vegetables in a collective term as *muroho* in Tshivenḓa, *morogo* in Sepedi and *imifino* in isiZulu and isiXhosa.

Because of unreliable weather and climate conditions and a lack of marketing, indigenous vegetable usage has declined remarkably over the years. The unavailability of some species as a result of poor rainfall in certain regions has robbed communities of valuable nutrition and medicines. However, several surveys conducted in South Africa on indigenous vegetables focused on production potential. The surveys are based on the premise that indeed indigenous vegetables do possess nutritional and medicinal values.

Cultural beliefs and practices necessitated the identification, utilisation and preservation of indigenous vegetables. Indigenous ways of understanding the nutrition and medicinal values of indigenous vegetables were realised through frequent utilisation, which led to vigour and vitality. Although over the years, there has been a marked decline in the use of indigenous vegetables because of several factors, there is a growing demand for indigenous vegetables because of challenges faced by rural and urban people on ever-increasing illnesses accompanied by poor diet referred to as nutrition transition. Indigenous vegetables can no longer be regarded as weeds and poor male's plants. In the process of decolonising our communities regarding western diets, indigenous vegetables can no longer be called 'poor male's food' and should not be promoted as such.

The challenge faced in the use and promotion of indigenous vegetables is because of a lack of documenting ways of harvesting, cooking and preservation. However, communities have harvested, cooked, dried and eaten *merogo* (plural for *morogo*). The documentation was not even necessary at the time because communities had their methods and knowledge of capturing and understanding different vegetable species. It should also be noted that indigenous vegetables were introduced in Europe and South America, where they are now more popular than in Africa, where they originate (Schippers 2002). This shows how colonised Africans are and proves there is an urgency to decolonise the African mind.

There are many indigenous vegetables in South Africa, and these are known by different indigenous groups or communities. Although this is the case, this chapter focuses on seven indigenous vegetables, namely, *leroto/murudi/bangala* (*Cleome gynandra*), *thepe/thebe* (*Amaranthus* spp.), *Monawa/munawa* (Cowpea), *thelele/delele* (*Corchorus tridens*), *muxe* (*Solanum nigrum*), *mushidzhi* (*Bidens pilosa*/blackjack) and *tshibavhe/nngu/nkaka* (*Momordica balsamina/Momordica foetida*).

Importance of indigenous vegetables

Indigenous vegetables as a source of income

The traditional motives for creating their markets or selling points were based on *botho/ubuntu* (humanness). The markets were aimed to assist households

without expecting any financial returns. The indigenous vegetables were harvested from the wild and utilised by different households within the community. The notion that vegetables are utilised by poor households is no justification to regard the vegetables as 'poor male's food'. The vegetables are regarded as such for the reason that they are cheap and accessible. Indigenous vegetables are sometimes cooked and dried for household use and for sale. Indigenous vegetables play a vital role in generating subsistence incomes as some of the street vendors sell them at shopping complexes as well as along roads. In Southeast Nigeria, indigenous vegetables such as Amaranthus are sold at a high price when compared with routinely cultivated species (Adebooye & Opabode 2004). In Kenya and Uganda, indigenous vegetables give people an opportunity to live beyond the minimum standard wage and to earn a living (Abukutsa-Onyango 2003; Musinguzi, Kikafunda & Kiremire 2006). Indigenous vegetables are grown for both consumption and profit in most parts of Africa.

According to Van Rensburg et al. (2007), in South Africa, *Solanum retroflexum Dun* has been elevated from a plant that is harvested in the wild to that of a fresh produce commodity. The indigenous vegetable is now cultivated under irrigation by local farmers and sold in supermarket outlets in the Vhembe District of the Limpopo province and at fresh produce markets (Van Rensburg et al. 2007). Indigenous vegetables can therefore provide income for rural communities, especially for the poor and the unemployed. Females gather and sell the young tender leaves of *Cleome gynandra* in rural and urban markets (Chweya & Mnzava 1997; Van Wyk & Gericke 2000). Females are mostly the knowledge holders of indigenous ways of harvesting, cooking, drying and selling indigenous vegetables.

Nutritional and medicinal value of indigenous vegetables

Many indigenous vegetables contain adequate amounts of bioactive components, which function interactively to scavenge free radicals from the body (Gurib-Fakim 2006). Consumption of natural antioxidants reduces the risk of developing cancer, cardiovascular disease, diabetes and inflammation (Sun et al. 2002; Yang et al. 2001). Medicinal and health benefits of *leroto/murudi/bangala/*spider flower/cat's whiskers (*Cleome gynandra*), *thepe/thebe* (*Amaranthus* spp.), *monawa/munawa* (Cowpea), *thelele/delele* (*Corchorus tridens*), muxe (*Solanum nigrum*), *mushidzhi* (blackjack/*Bidens pilosa*) and *nngu/tshibavhe* (*Momordica balsamina*, *Momordica foetida*), are presented in this section.

Rural communities are knowledgeable about the nutritional and medicinal value of indigenous vegetables. Community members have examined their food systems and culturally accepted the taste, colour and smell. In a study by Maundu, Ngugi and Kabuye (1999), respondents said they consider

indigenous vegetables important because of their use in curing diseases. Combined with modern pharmaceuticals, indigenous vegetables can cure stomach aches, remove worms, cure measles and strengthen the bones (Maundu et al. 1999).

Types of indigenous vegetables

Cleome gynandra (*leroto/murudi/bangala*/spider flower/cat's whiskers)

Cleome gynandra contains several nutrients and can be used to treat minor ailments (Mishra, Moharana & Dash 2011; Onyango et al. 2013). The crushed leaves make a concoction that is drunk to cure diseases such as scurvy, while cooked leaves are consumed to help improve eyesight, provide energy and treat marasmus (Mishra et al. 2011; Opole, Chweya & Imungi 1995). In addition, regular consumption of *Cleome gynandra* by pregnant females helps ease childbirth by reducing the length of labour and regaining normal health after delivery. Experts argue that *Cleome gynandra* is used by pregnant females during childbirth and by mothers to stimulate milk let-down as well as milk production (Van den Heever & Venter 2007). In Kenya, females are encouraged to use *Cleome gynandra* before and after childbirth. On the contrary, the consumption of *Cleome gynandra* helps to promote male power and provides energy. Furthermore, Mishra et al. (2011) indicated that tea of boiled leaves or roots is given to pregnant females to facilitate childbirth.

Mishra et al. (2011) indicated that sap from *Cleome gynandra* leaves may be used as an analgesic, particularly for headache, stomachache, earache, chest pain, constipation, conjunctivitis, thread-worm infection and epileptic fits. In addition, the decoction of roots is used to treat fevers. Leaves are reported to have anti-inflammatory properties (Mishra et al. 2011). Furthermore, *leroto* is used to treat dysentery, gonorrhoea, malaria and rheumatoid arthritis. Chweya and Mnzava (1997) reported that leaves are applied over wounds to prevent sepsis. Van Wyk and Gericke (2000) posited that *Cleome gynandra* could treat diabetes, gout, hyperlipidaemia and gastrointestinal tract infections.

Amaranthus spinosus (*thebe*/pigweed)

Amaranthus spinosus is used for treating various ailments, which indicates that *Amaranthus* has enormous nutritional and medicinal potential. The smooth paste of leaves and roots is applied as a poultice to get relief from skin disease or disorders such as abscess, bruises, burn, eczema, inflammation and wound (Ganjare & Raut 2019). The roots are given to children for laxative action and possess good diuretic properties. The seed is also used internally for the treatment of internal bleeding, diarrhoea and excessive menstruation and externally as a poultice for broken bones. The boiled leaves of *Amaranthus*

are given for 2–3 days to cure jaundice, some kinds of rheumatic pain and stomachache (Einhelig & Rasumussen 1978).

Amaranthus spinosus contains phytochemicals that belong to the alkaloid, amino acids, flavonoids, glycosides, lipids, phenolic acids, terpenoids, steroids, saponins, betalains, catechuic tannins and carotenoids. Vitamin C, phenolic and flavonoids are phytochemical compounds responsible for antioxidant activity in fruits and vegetables (Jimenez-Aguilar & Grusak 2017). Sebasttian and Bhandari (1984) reported that *A. spinosus* is used as a diuretic purgative and refringent and to treat cholera, piles and snake bite.

Vigna unguicutata L. Walp (cowpeas leaves/*munawa*)

Venâncio et al. (2003) reported that protein in cowpea is thought to be a functional food with anti-diabetic as it contains isolate that has a similar molecular weight and amino acid sequence as bovine insulin. In addition, cowpea has an antioxidant compound that helps protect the body from harmful free radicals. Barnes, Uruakpa and Udenigwe (2015) provided evidence to support the prospective utilisation of cowpea peptides as anti-diabetic agents. In addition, the findings demonstrate that the cowpea peptides can function in glucose metabolism via phosphorylation of AKT (a form of protein kinase B; PKB), which can lead to a reduction in blood glucose levels. Ye, Wang and Ng (2000) reported that cowpea peptides (α- and β-antifungal proteins) have antifungal and anti-viral properties.

Singh et al. (2015) reported that *Vigna unguiculata* beans were traditionally used to treat neuritis, insomnia, weakness of memory, dyspepsia, indigestion, needles in limbs and sensation of pins. In addition, *V. unguiculata* is a good source of protein and amino acids. Some of these amino acids play an important role in the management of sickle cell disease. The decoction of leaves is used to treat hyperacidity, nausea and vomiting (Singh et al. 2015).

Hardwick (2013) reported that *V. unguiculata* seeds are used to treat burns, chest pains, epilepsy, fever, headaches, menstruation and childbirth. The plant is used in measles, smallpox, adenitis and sores. Gupta, Lakshimi and Prakash (2006) reported that 'decoction or soup is used in the affection of the liver and spleen, intestinal colic, in leucorrhoea and urinary discharges'. The seeds are used as an astringent, antipyretic and diuretic and are also used to treat cardiovascular diseases. The sprout cowpeas have increased vitamin C content (Devi, Kushwaha & Kumar 2015). It is important to note that cowpea leaves are a good source of vitamin C, beta-carotene, folate and minerals such as iron and calcium (Imungi & Potter 1983). Therefore, the consumption of cowpea

leaves can contribute to the management of vitamin C deficiency syndrome (Gupta et al. 2006). Dinesh, Bembrekar and Sharma (2013) reported that 100 ml of *V. unguiculata* seeds decoction can be taken twice a day orally for 30 days to dissolve kidney stones.

Corchorus tridens (*thelele/delele*)

Delele is one of the indigenous leafy vegetables in South Africa and is mostly consumed in large quantities in the eastern part of Limpopo province. *Corchorus tridens* thrive well in rain-fed conditions in sub-Saharan Africa, where it grows in the wild and on farm holdings in KwaZulu-Natal, Mpumalanga, Limpopo and Gauteng provinces (Modi, Modi & Hendriks 2006). It is used to treat gonorrhoea, chronic cystitis, pain, fever and tumours (Zakaria et al. 2006). Previous research reported that *Corchorus* species contain high levels of iron and folate, which is useful in the prevention of anaemia (Oyedele, Asonugho & Awotoye 2006; Steyn et al. 2001). This was corroborated by the study conducted by Ndlovu and Afolayan (2008) and Choudhary et al. (2013), which reported that *Corchorus olitorius L.* contains a high concentration of iron, zinc, magnesium and calcium. In addition, the leaves contain high levels of fibre and protein. The high levels of fibre contained in the leaves can help in preventing constipation and can serve as a laxative. Steyn et al. (2001) also reported that *Corchorus* species are a good source of protein, vitamin A, vitamin C, vitamin E, calcium and iron. Zakaria et al. (2006) reported that wild okra could treat pain, fever, gonorrhoea, chronic cystitis and tumours. The leaves of *Corchorus tridens* are used medicinally as a demulcent, bitter tonic, stomachic and laxative, carminative anthelmintic, astringent and intestinal antiseptic. Duke and Wain (1981) earlier reported that *Corchorus* is used as part of folk medicine for aches and pains, dysentery, enteritis, fever, pectoral pains and tumours. Islam (2013) reported that *Corchorus tridens* leaves are used as a relish that is consumed with porridge. Furthermore, the *Corchorus tridens* leaves are used to treat fever, chronic cystitis, cold and tumours. Van Rensburg et al. (2004) indicated that *Corchorus* also helps ease indigestion and is used as a laxative. Duke (1983) reported that *Corchorus* could also be used for piles and tumours.

Islam (2013) reported that *Corchorus* leaves are good sources of beta-carotene, iron, calcium and vitamin C. The *Corchorus* leaves are used as a soup-based dish that is eaten with meat or lentils in Arab countries such as Egypt, Jordan and Syria.

Solanum nigrum (*muxe*)

Lee and Lim (2006) reported that *Solanum nigrum* is rich in phytochemicals with pharmacological prospects. Traditionally, the plant has been used to

treat pain, inflammation and fever (Acharya & Pokhrel 2006; Atanu, Ebiloma & Ajayi 2011; Zakaria et al. 2006). In addition, several compounds isolated from *Solanum nigrum* plant were found to have pharmacological relevance (Atanu et al. 2011). Sun et al. (2006) stated that the major organic acids in *Solanum nigrum* are acetic acids, tartaric acid, malic acid and citric acids. An et al. (2006) suggested that *Solanum nigrum* holds cancer-prevention properties as it can interfere with the structure and function of the tumour cell members, disturb the synthesis of DNA (deoxyribonucleic acid) and RNA (ribonucleic acid), change the cell cycle distribution, block the anti-apoptotic pathway of NF-kappaB, activate caspase cascade's reaction and increase the production of nitric oxide.

According to a review conducted by Jain et al. (2011), the *Solanum nigrum* plant holds anti-cancer, anti-inflammatory, anti-seizure, antipyretic, anti-poison and antioxidant properties. Zakaria et al. (2009) described *Solanum nigrum* as a plant in which aqueous extracts exhibit anti-nociceptive, anti-inflammatory and antipyretic activities when assessed using various animal models. Saleem et al. (2009) indicated that *Solanum nigrum* leaves are used to treat skin swollen joints caused by diseases such as rheumatism and gout. In addition, the leaves are used in the treatment of skin diseases and tuberculosis. The decoction of berries and flowers is used to treat cough and the infection of the upper layer of the skin, while leaves are used to treat oedema, nausea and nervous disorders (Saleem et al. 2009). The decoction of the berries and flowers is useful in cough, erysipelas and inflammatory diseases caused by hemolytic streptococcus (Saleem et al. 2009). The juices of berries are used for anti-diarrhoea, ophthalmopathy and hydrophobia.

The *Solanum nigrum* plant leaves show the presence of the following phytochemicals: flavonoids, triterpenes, saponins and steroids (Zakaria et al. 2009). Saleem et al. (2009) reported that the *Solanum nigrum* plant contains alkaloids, flavonoids, tannins, saponins, glycosides, protein, carbohydrates, coumarins and phytosterols.

***Bidens pilosa* (blackjack/*mushidzhi*)**

Horiuchi and Seyama (2006) reported that different parts of *Bidens pilosa* plants have been used as traditional folk medicine to treat various ailments, especially in Africa. In South Africa, *Bidens pilosa* has been used traditionally by indigenous people from different cultural groups as medicine in a range of treatments. A review completed by Bartolome, Villaseñor and Yang (2013) and Subhuti (2013) indicated that *Bidens pilosa* plants have bioactive compounds that could be antibacterial, anti-hyperglycaemic, antidiabetic,

antidysenteric, anti-inflammatory, antimalarial, antiseptic, anti-cancerous, antipyretic, liver-protective and antihypertensive, antifungal, anti-oxidant, immunomodulatory and anti-ulcerative.

In Colombia, *Bidens pilosa* is used by native communities for treating common infections (Rojas et al. 2006). The *Bidens pilosa* decoctions, tea and juice can be used to treat respiratory infections (Gonzalez 1980). *Bidens pilosa* can be used externally on infected wounds or burns (Rojas et al. 2006). *Bidens pilosa* is used to treat stomach disorders and infections, including peptic ulcers, mouth ulcers, diarrhoea, diabetes mellitus, inflammation, enteritis, dysentery, pharyngitis, diuretic and anti-rheumatic (Arthur, Naidoo & Coopoosamy 2012; Brandão et al. 1997, 1998). The leaf decoction or extract is used to treat headaches, malaria, ear infections, kidney problems and flatulence (Subhuti 2013). In addition, the whole plant can be used as a poison-antidote, for snake-bite and small-pox (Burkhill 1985), while leaf-infusions can be used to manage hang-over. However, in South Africa, fresh young leaves of *Bidens pilosa* are cooked and consumed as a relish.

Momordica balsamina (*Momordica foetida* and other spp)

Momordica balsamina and *Momordica foetida* are commonly known as *tshibavhe* or *nngu* in Tshivenḓa. The *Momordica balsamina* and *Momordica foetida* leaves are commonly cooked and mixed with other indigenous vegetables and consumed as relish in most parts of the Limpopo province in South Africa. *Momordica* species are believed to improve numerous infections, including cancer, leukaemia and diabetes (Kumar & Bhowmik 2010). The *Momordica* species leaves and fruit (bitter melon) are commonly eaten as a vegetable in most parts of South Africa. On the other hand, the bitter melon and leaves of the *Momordica* plant have been used to treat tumours, asthma, skin infections, gastrointestinal problems and hypertension (Kumar & Bhowmik 2010). The bitter melon contains steroidal saponins, which are known as *charantin*, insulin-like peptides and alkaloids (Joseph & Jini 2013). These steroidal saponins in the bitter melon have been reported to lower blood glucose levels, which benefits diabetes mellitus patients.

The research conducted by Quin (1959) (South Africa), Maundu et al. (1999) (Kenya), Schippers (2002) (United Kingdom [UK]), Chweya and Eyzaguirre (1999) (Italy), Matlhare et al. (1999) (Botswana) reflect on the value of indigenous vegetables. The authors also presented their experience with indigenous vegetable usage. The indigenous vegetables with nutritional, phytochemical and medicinal values are presented in Table 13.1.

TABLE 13.1: The nutritional and medicinal value of indigenous plants.

Local name	Scientific name and English name	Nutrition	Phytochemical	Medicinal
Leroto (*murudi/ bangala /cat's whiskers*)	*Cleome gynadra* Spider plant	Rich source of calcium (Ca), magnesium (Mg), and iron (Fe), vitamins A and C and methionine	Leaf extracts contain high amounts of phenolics, flavonoids, flavanols, and a considerable amount of proanthocyanidin Stem extracts contain a high amount of proanthocyanidin The plant is generally low in tannins, alkaloids and saponins	Root infusion for chest complain, it is water from boiled leaves used to treat diarrhoea and cleanse eyes. It is believed that cooked *leroto* is used by females before and after giving birth. It is believed that the plant restores blood supply since it contains high levels of iron, magnesium and calcium. In other areas, it is used for pneumonia (Chweya & Mnzava 1997).
Thepe (*thebe/ pigweed*)	*Amaranthus* Amaranth	High nutritional value due to great levels of essential micronutrients (carotene, vitamin C, iron and calcium). Rich in lysine.	Leaves and stems contain alkaloids, amino acids, flavonoids, glycosides, lipids, phenolic acids, terpenoids, steroids, saponins, betalains, catechuic tannins and carotenoids	Important for the treatment of cardiovascular diseases. Seeds are vital to ingest for the treatment of internal bleeding, diarrhoea, excessive menstruation and external poultice for broken bones.
Monawa (*munawa*)	*Vigna unguiculata* Cowpea	Rich in protein carbohydrates, calcium, dietary fibre and vitamin B complex	Seeds and leaves contain flavonoids and phenolic compounds	Boiled leaves water, snorted through the nose when infants scratch their noses, also have antioxidant properties
Thelele (*delele*)	*Corchorus spp.*	Protein, vitamins A and C, calcium, phosphorus and iron	-	Scrapings of the root are put into teeth cavities to ease pain and are eaten to ease child delivery
Muxe	*Solanum nigrum* Black nightshade	Vitamin A and C, calcium and iron	-	Unripe fruits are applied to aching teeth and squeezed on the infant's gums to ease pain during teething. Leaves are used to relieve stomach aches. Leaves and fruits are pounded and the extract is used for tonsillitis.
Mushidzhi	*Bidens pilosa L.*	Crude fibre, calcium and zinc	Leaves and roots contain alkaloids, saponins, tannins and phenols Aromatics, acetylacetone, aurons, auron derivatives, caffeoylquinic acid derivatives, diterpenes, glycosides, glycosylated porphyrins, polyacetylenic polyacetylenes, p-coumaric acids, flavonoids and flavonoid glycosides, sesquiterpenes, phenylheptadiynol, phenylpropanoid glucosides and pheophytins	Roots, leaves and seeds are ingested as decoctions, tea and juice preparations to treat respiratory infections Ingested as tea for treating conditions such as diabetes, inflammation, enteritis, dysentery, pharyngitis, diuretic and anti-rheumatic poultice and can be applied directly on infected wounds or burns Anticancerous, anti-inflammatory, anti-oxidant, anti-diabetic and anti-hyperglycemic, immunomodulatory, antimalarial, antibacterial, antifungal, antihypertensive, vasodilatory and anti-ulcerative properties
Nngu (*tshibavhe*)	*Momordica balsamina* (*Momordica foetida* and other spp.)	Calcium, iron, magnesium, zinc, β-carotene, foliate and vitamin C	Alkaloids, flavonoids, tannins, phenolic compounds, gallic acids, gentisic acids, catechins, chlorogenic acids and *epicatechins*	Antidiabetic, antimicrobial, anthelmintic bioactivity, abortifacient, antibacterial, antiviral, anti-oxidant, antifungal, anti-inflammatory and anti-allergic

Preparation, preservation and storage of indigenous vegetables

Indigenous people used different food processing and preservation methods to ensure that they had food throughout the year. These indigenous food systems ensured that food is stored and remained safe for human consumption, resulting in food security. Perishable products such as vegetables are prone to high post-harvest loss. It is estimated that half of the vegetables and fruit produced are lost after harvest due to limited food processing and preservation capacity (Olunike 2014). Post-harvest loss can be reduced through the implementation of good food processing and preservation methods which will ensure more food are available for the consumers (Hodges, Buzby & Bennet 2011). Asogwa, Okaye and Oni (2017) indicated that indigenous knowledge, skills and practices on food handling, processing, preservation and storage are underutilised, and these can reduce post-harvest loss and improve food security.

African females developed an indigenous technology of food handling, processing, preservation and storage over the years, which worked for them. Kamwendo and Kamwendo (2014) indicated that the bulk of agricultural produce in Africa is preserved and processed using simple indigenous knowledge and practices, which are passed from one generation to the next by word of mouth. Females use these techniques predominantly to provide income and employment. Traditional and indigenous technologies of 'food processing and preservation date back thousands of years and form part of the culture of the people in Africa' (Olunike 2014).

Indigenous people use different food preservation methods such as sun drying, fermentation, soaking and germination. Oniang'o, Allotey and Malaba (2004) describe drying as one of the oldest food preservation methods used by indigenous people as it removes water from farm produce to a reasonable amount and extends shelf-life. Sun drying is an inexpensive method of food preservation used by indigenous people. Drying of vegetables has resulted in extended shelf-life by up to a year. In Africa, vegetables are sun-dried after boiling in salt water for a few minutes, and they are stored in a safe, dry place (Oniang'o et al. 2004). Food preserved and stored ensure households are food secure even in dry seasons (Kamwendo & Kamwendo 2014).

Implications of nutritious indigenous vegetables

In promoting the utilisation of indigenous vegetables in addressing nutrition and deepening health issues in South Africa and sub-Saharan Africa, the government should implement policies in favour of indigenous vegetable crops.

Furthermore, crop scientists should acknowledge that indigenous vegetables have more potential than exotic vegetables in addressing poverty and health-related challenges in the country. A decolonisation approach to research is required for researchers who still regard indigenous vegetables as weeds, poor male's plants and unmarketable. Indigenous knowledge holders are key in promoting and marketing vegetables in terms of their nutritive and health care values. Indigenous vegetables contribute greatly to the well-being of rural communities as a source of minerals and vitamins. Researchers who attempt to assess these vegetables should also consider indigenous epistemologies and cosmology. The success of mitigating malnutrition and the deepening health care crisis can only be achieved through Afrocentric underpinnings.

Conclusion

Overall, there is a huge gap between indigenous knowledge holders and orthodox food scientists, nutritionists and dieticians in South Africa. In considering indigenous epistemologies, nutritionists, dieticians and food scientists in sub-Saharan Africa should include indigenous vegetables in the hospital diets. This will ensure that indigenous people are served local and familiar foods, especially in rural areas. Indigenous vegetables can contribute greatly to addressing the food security crisis due to their potential nutritive and medicinal value.

Health awareness campaigns on the use of indigenous vegetables are required. As indigenous vegetables are non-toxic food, policies and laws governing research, distribution and marketing should change to address rural communities and promote their foodstuff without limiting factors. Indigenous ways of doing things will remain and food scientists, trained in western ways, should learn from indigenous knowledge holders.

Glossary

- ***antioxidants*:** A group of chemical substances that prevent and or repair damage to cells caused by exposure to oxidising agents and smoke normally produced in the body.
- ***food security*:** When people at all times have physical, social and economic access to sufficient, safe and nutritious foods.
- ***food system*:** Described as the process that influences nutrition, food, health, community development and agriculture.
- ***functional foods*:** Those food products that have a physiological benefit or reduce the risk of chronic disease beyond basic nutritional functions.
- ***indigenous vegetables*:** Vegetables that are locally important for the sustainability of the economy, health and nutrition. They grow spontaneously

in the wild or farmland and thrive well under rain-fed conditions and adapt well to harsh environments.

- ***Indigenous*:** Originating or occurring naturally in a particular place; native.
- ***malnutrition*:** Refers to the imbalance of cells between the supply of nutrients and energy and the body's demand for them to ensure growth, maintenance and specific functions.
- ***medicinal*:** A substance or vegetable that contains healing properties.
- ***phytochemicals*:** Chemical substances found in plants that may benefit the health of human beings.
- ***the nutrition transition*:** Change or shift in dietary consumption and energy expenditure that accompany changes in economic development, lifestyle, urbanisation and demography.
- ***western diets*:** Those diets that contain a high amount of saturated fats, refined carbohydrates and salt.

Conclusion

General conclusion

Fhumulani M. Mulaudzi
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Raikane J. Seretlo
Department of Nursing,
Faculty of Health Sciences, University of Pretoria,
Pretoria, South Africa

Introduction

This book consists of thirteen chapters, and all of these chapters address indigenous knowledge systems (IKSs) within the health care context. This book advocates for the co-existence of African and Western health care practices and highlights the importance and implications of incorporating both practices.

Research studies have been conducted on many aspects of indigenous health care; however, there are no peer-reviewed books that address indigenous health care issues. As the debate on decolonising the curriculum continues, it has become clear that there is a need for more literature that addresses indigenous health care methods. The IKS in health care has been marginalised for many years. Its value has now been legitimised by the World Health Organization (WHO) when it calls for all countries to incorporate indigenous and traditional medicine in their primary health care systems.

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Our health care system in South Africa still recognises allopathic health care as the main recognised mode of health care. The health care system is still monolithic as opposed to being pluralistic and incorporates other methods of care. Most of our students are not exposed to the science of the IKS. They are not made aware of the value that the IKS can play in advancing health care and the socio-economic status of the country. Indigenous health care practice needs to be appraised and given due acknowledgement to address its effectiveness and accessibility to huge sectors of the communities.

The authors in this book used the anti-colonial framework to liberate themselves from western ideologies and express their views from an indigenous lens. The framework requires that the authors be positioned inside Afrocentric ideals encompassing African codes, paradigms, symbols, motives and myths that give meaning to the history of the African subject and a sense of place in the world arena. Most of the work was based on the research conducted by the authors to advance indigenous ways of treating diseases and illnesses and acknowledge traditional health care practitioners' perspectives and voices.

Implications to the health care professionals

Most rural communities are poor, and there is also a scarcity of resources, resulting in people not receiving adequate care. However, there are many resources available in the community that can be included and used by the primary health care team to offer promotive, preventive and curative health care. This poses a challenge to health care professionals to consider the involvement of indigenous methods and practices in health care delivery, as they remain the existing source of health care for the people. As we grapple with the achievement of sustainable development goals, there is a need for health care professionals to understand the role that IKS can play in ensuring that some of the sustainable goals, such as food security and human well-being.

The academics in health care sciences will find this book useful as it will empower them with knowledge and guidance which will allow them to understand the indigenous knowledge, methods of care, indigenous disease patterns, cultural beliefs and practices of the community they serve and assist them in teaching students cultural safety care. The IKS in health care focused on sharing indigenous knowledge and practices that are culturally specific. The focus was on the identification of indigenous ailments that affect all ages, their diagnosis and assessment, as well as healing modalities. The holistic nature of healing was displayed. This book documented the significance of IKSs, rituals, customs, practices and indigenous healing modalities used to protect and prevent diseases.

This book also highlighted the different causes of diseases and the importance of the belief systems, attitudes and practices of the patient in understanding diseases and treatment modalities.

Holistic nature of indigenous health care

Health care based on IKS is holistic in nature. The belief is that a living human being is surrounded by nature, plants, water, animals and environmental factors such as climates which all have a bearing on the healthy living of an individual. To render a holistic health care service, an attitude of openness and respect for patients' beliefs and customs is important. Health care professionals need to know the communities they serve concerning the available resources. The Western-trained health care professionals should embrace the African ways of understanding and treating diseases and illnesses and work closely with traditional health care practitioners in health care programmes. A nurse should be a key person in coordinating all aspects of health care in the community and be involved in primary, secondary and tertiary activities.

Summary

In conclusion, the authors have managed to cover the different spectrums of preventive, promotive and curative health care across the spectrum. This book covered different aspects of indigenous health care topics such as communication, neonatal care, adolescent health, senior individuals, gender issues, nutrition and communicable and non-communicable diseases. Recommendations made in this book can be used to inform the health care system and practices that can enable health care professionals to interact with patients during consultations within the health care system in Africa. This book will be useful to all members of multidisciplinary health care researchers and indigenous scholars.

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Chapter 7

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Chapter 13

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This fascinating and relevant book will assist primary health care professionals in taking cognisance of the indigenous practices that affect the health of African communities.

The area of indigenous knowledge systems in health care has always been one that health care professionals refrain from debating, as indigenous practices are primarily undermined. The content of this book brings light to indigenous practices that will enable clinical health care professionals to openly discuss them with clients without judgement, as well as improve provider-client health care communication. People across Africa has been made to believe that their health care practices are primitive due to Western culture and ideology. This has forced them to conceal these alternate practices, including positive practices that benefit the community. In trying to gain respect within the South African health care sector, indigenous traditional health care practitioners and their clients have altered their mode of practice – many continuing their practices unpronounced. This scholarly book will contribute to gaining a better understanding of their traditional methods and changing the stereotype.

This book further recommends accommodating practices detrimental to the indigenous community's overall health while assisting higher learning institutions (HILs) in decolonising their curricula. In summary, this book acknowledges the value of indigenous knowledge systems within the African context and aims to restore Africans' cultural dignity. Research and recommendations for improving health care systems in African countries are included in *Working with indigenous knowledge: Strategies for health care professionals* because it promotes an open dialogue about indigenous knowledge systems within the health care fraternity, fostering collaborative health care with Western practices.

Prof. Mashudu Davhana-Maselesele,
Walter Sisulu University, Mthatha, South Africa

This book was fascinating to read. Some critical insights into the practice of all health care practitioners were brought to the fore. Additionally, this has demonstrated that not everything that is Eurocentric, in terms of health care, is a good thing. In some instances, indigenous practices are effective and beneficial to clients seeking health care services and should therefore be encouraged. Indigenous knowledge must be included in the higher education curriculum to enable health care providers to render relevant and culturally-congruent health care services.

Prof. Agnes Makhene, Department of Nursing, Faculty of Health Sciences, University of Johannesburg, Johannesburg, South Africa

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