

1. Introduction

1.1 Background

Africans have been using traditional medicine since time immemorial. According to World Health Organization (WHO), up to 80% of the African population uses traditional medicine to help meet their health care needs. In Asia and Latin America, populations continue to use traditional medicine as a result of historical circumstances and cultural beliefs. In China, traditional medicine accounts for around 40% of all health care delivered (<http://www.who.int/en>).

Traditional medicine is highly popular in many developing countries because it is firmly embedded within wider belief systems. The broad use of traditional medicine is often attributed to its accessibility and affordability. Usually, traditional medicine is often the only affordable means of health care in many developing countries, especially for the world's poorest patients (*ibid*).

In most cases the traditional healers understand the family history of most of their patients (Makinde 1988: 103). Consulting an *inyanga* or *sangoma* is part of culture of most Africans. The *inyangas* have always been using plants and animal substances as preventive, protective, and curative medicine. Majority of the Africans believe traditional healers understand the causes of their illnesses and diseases better than the Western medical doctors.

The popular media in South Africa often carry horror stories of traditional medicine and it's practitioners, while sensationalist articles have escalated with the rise of AIDS epidemic. Reports of the prescription of mysterious herbal treatments or *muti*, healers who claim to have found the cure for AIDS, and unethical and unsavoury behaviour relating to the treatment of patients can often be found on the pages of newspapers and magazines.

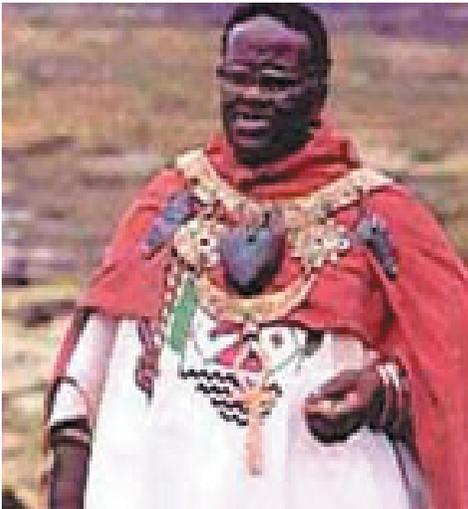


Fig 1.1: Credo Mutwa, famous Sanusi

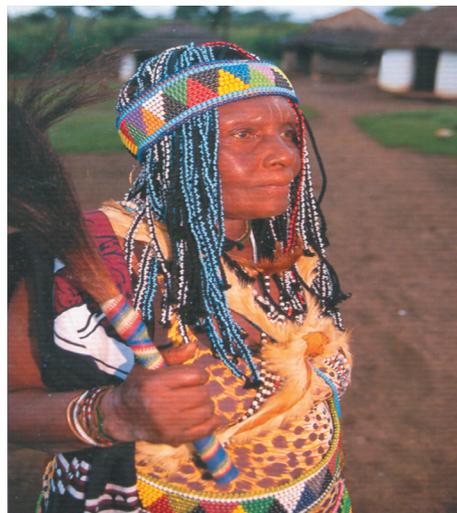


Fig 1.2: Sangoma

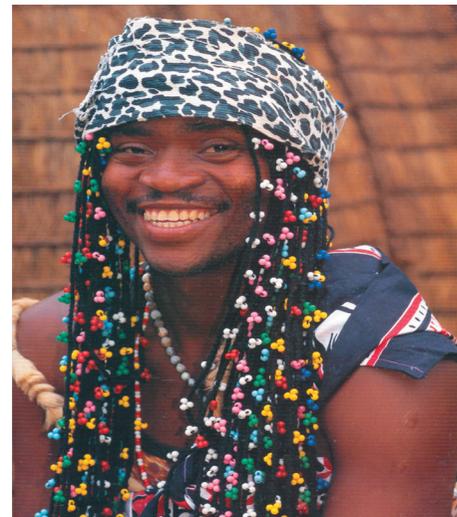


Fig 1.3: Lungani Ndlovu, famous sangoma

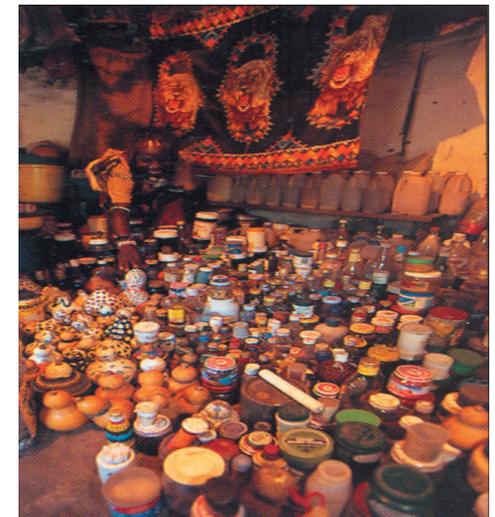


Fig 1.4: Muti

Since the turn of the last century, there has been an influx of people in the city due to rapid urbanisation. Most of the people were coming from the rural areas and had to adapt to a life in the city. Therefore, people in the cities found themselves travelling long distances to consult either an *inyanga* or *sangoma* in the rural areas.

There are, of course, problems that need to be addressed if the traditional healer is going to be a continuous effective participant in the health care system. Firstly, many *inyangas* and *sangomas* are reluctant to allow their formulae to be put on record or tested. There is sort of secrecy surrounding the practice, and this is a serious handicap. The secretive nature of their knowledge has made the “principle and practice of traditional medicine inaccessible to curious minds” (Gbadgesin 1991:133).

Without records, many of the “formulae that could be useful have died with their discoverers” (*ibid*). Hence it is said, “the death of a genuine healer is tantamount to the loss of library” (Makinde 1191:91). Western medical doctors, on the other hand, do not encourage such records because of their negative attitude towards traditional medicine.

As Akin Makinde (*ibid*) wrote, the main reason why traditional medicine has led to no discovery in the medical sciences is because traditional healers do not reveal their secrets to anyone except their children or immediate relatives. This is due to the fact that many of them have long family traditions as healers and new generations get introduced to the intricacies early in life. It is not unusual for a child to start learning at the age of seven. In such a situation, by the time he becomes an adult he must have an encyclopaedic knowledge of herbal medicine (Gbadegesin 1991:132).



Figures 1.5-1.8 : Durban muti market (Architects: OMM)

1.2 The Client

The Government has realised the importance of incorporating traditional health practice within the health sector. In 31 August 2005, South Africa joined the rest of the world to celebrate African Traditional Medicines Day. The World Health Organisation (WHO) declared the 31st of August as an African Health Day in 2003 (<http://www.info.gov.za>)

The theme of last year (2005) was: “African traditional medicine: Contributing to preventing HIV infection.” The theme was in line with the resolution taken by the African Ministers of Health at the 55th session of the WHO Regional Committee held in Maputo earlier this year to declare the 2006 as the “Year for Acceleration of HIV Prevention in Africa” (*ibid*).

Earlier this year (2006), at a conference for researchers and research-funders, the Minister of Health manto Tshabalala-Msimang said in her speech that “research and development of African traditional medicine should be one of the main priorities for research in South Africa” (<http://www.doh.gov.za.docs/news>).

Understanding that we are Africans with a particularly history dating back several centuries, Minister Tshabalala-Msimang said South Africa needs to pay attention to those things that sustained the health of Africans throughout their history of denied access to health and other basic services.

Tshabalala-Msimang said at the conference that there is a need to invest the resources and efforts into the research and development of African traditional medicines which have been suppressed through several years of colonialism and apartheid. (*ibid*).



Fig 1.9: Entrance of Kwa-Mai-Mai
Architect: Rob Lloyd



Fig 1.10: KwaMai-Mai



Fig 1.11: Faraday Muti Market
Architects: Albonico Sacks

“Our success in the research and development of African traditional medicine will probably be the best contribution the health sector can make to the African Renaissance” *Health Minister Manto Tshabala-Msimang*

The Department of Health will soon launch the Council for Traditional Health Practitioners as required by the Traditional Health Practitioners Act (2003).

The Council will regulate traditional health practice by:

- Creating a registry for persons who engage in traditional health practice,
- Setting competency levels for practitioners,
- Maintain ethical and professional standards,
- And facilitate interaction with other sectors in the health system (*ibid*).

Traditional medicine has a major role to play in the health system covering areas such as health promotion, prevention, diagnosis and treatment of diseases.

According to the NEPAD Health Strategy report, about 23,000 qualified health professionals emigrate annually, while AIDS is taking its toll on the health workforce (<http://www.afro.who.int>). Therefore, Dingakeng Centre will help reduce the burden that is faced by the Department of Health of shortage of health workers in the country.

This health strategy follows the openness of NEPAD in looking into the root causes of Africa’s ills and Africa’s potential as the basis for lessons for the way forward. NEPAD proposes primary strategic directions for addressing the health problems and their underlying determinants.

It is a comprehensive strategy that takes into account existing initiatives and previously adopted decisions and resolutions by African Heads of State and Government and Ministers of Health, such as at the United Nations General Assemblies on AIDS and Children and in various regional fora, such as the annual OAU/AU, WHO Regional Committees for Africa and the Eastern

Mediterranean and at the African Heads of State Summits on AIDS, TB and other Infections and on Malaria (*ibid*).

Like most developing countries, stewardship of traditional medicine remains weak in Africa because of insufficient documentation and evidence on efficacy and safety of traditional medicines and a lack of knowledge of its practices and behaviours. The result is poor co-ordination between traditional medicine and the rest of the health system, and a lack of protection of intellectual property rights and endangered medicinal plants (*ibid*).

There is growing recognition of the importance of health in development strategies of NEPAD, exemplified by the fact that three of the Millennium Development Goals are directly related to health: reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases (*ibid*).

The NEPAD Health Strategy embraces the spirit of the Rio Declaration¹¹ that ‘Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature’. This vision was reiterated in the Declaration of the Johannesburg World Summit on Sustainable Development.

While recognizing that this vision remains distant for many African people, the NEPAD Health Strategy represents an important step to bestow future African generations with a real prospect of life free from a heavy burden of avoidable disease and disability and premature death.

1.2.1 Africa faces a huge burden of preventable disease, disability and death

Health is one of the most serious casualties consequent on the poverty, social exclusion, marginalisation and lack of sustainable development in Africa. The numbers of premature deaths (mortality) illustrate this starkly, but there are also high levels of suffering (morbidity) and disability. Africa's 800 million people face a huge burden of preventable and treatable health problems, which not only cause unnecessary death and suffering, but also undermine economic development and damage the continent's social fabric (<http://www.africa-union.org>).

The burden is in spite of the availability of suitable tools and technology for prevention and treatment and is largely rooted in poverty and in weak health systems. Indeed, although similar to China, India and the Eastern Mediterranean in the 1960s, the health status of the people of sub-Saharan Africa is now worse than any other region in the world (*Ibid*).

"Inyangas carry the secrets of a society... They know the history of the community." Credo Mutwa, from *Indaba My Children*.



Figure 1.12: Traditional Zulu huts

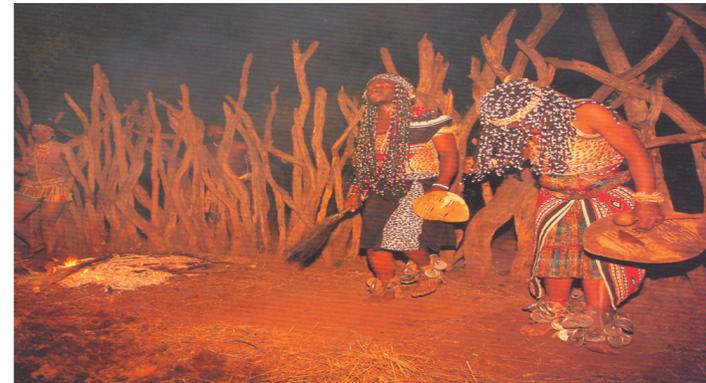
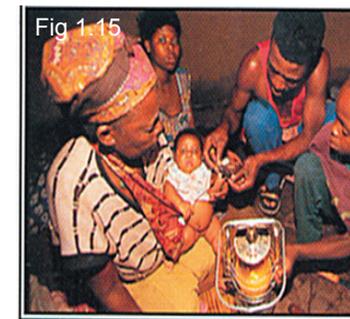


Figure 1.13: Sangomas during ritual dancing



Figures 1.14-1.15: Baby dedication ceremony to ancestors

1.3 Traditional Medicine v/s Complementary and Alternative Medicine



According to the WHO Traditional Medicine Strategy (2002-2005), the use of traditional medicine (TM) remains widespread in developing countries, while the use of complementary and alternative medicine (CAM) is increasing rapidly in developed countries. In many parts of the world, policy-makers, health professionals and the public are wrestling with questions about the safety, efficacy, quality, availability, preservation and further development of this type of health care.

1.3.1 What is Traditional Medicine (TM)?

“Traditional medicine” is a comprehensive term used to refer both to TM systems such as traditional Chinese medicine, Indian *ayurveda* and Arabic *unani* medicine, and to various forms of indigenous medicine. TM therapies include medication therapies (herbal medicines, animal parts and/or minerals) and non-medication therapies (without the use of medication, as in the case of acupuncture, manual therapies and spiritual therapies) (*ibid*).



Figures 1.16 : Traditional herbs

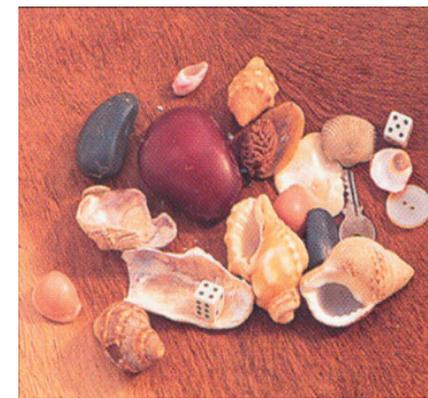


Figure 1.17: *Ditaola* (Bones)

In countries where the dominant health care system is based on allopathic medicine, or where TM has not been incorporated into the national health care system, TM is often termed “complementary”, “alternative” or “non-conventional” medicine (*ibid*).

TM is widely used and of rapidly growing health system and economic importance. In Africa up to 80% of the population uses TM to help meet their health care needs. In Asia and Latin America, populations continue to use TM as a result of historical circumstances and cultural beliefs. In China, TM accounts for around 40% of all health care delivered.

Meanwhile, in many developed countries, CAM is becoming more and more popular. The percentage of the population which has used CAM at least once is 48% in Australia, 70% in Canada, 42% in USA, 38% in Belgium and 75% in France (*ibid*).



Figure 1.18: Sangomas communicating with *badimo* (ancestors)



Figure 1.19: Khekhekhe leading *mathwasa* (initiates)



Figure 1.20: *Mathwasa* dancing during initiation ceremony

1.3.2 Why such broad use?

1. Affordable and accessible in developing countries

In developing countries, the broad use of TM is often attributable to its accessibility and affordability. In Uganda, for instance, the ratio of TM practitioners to population is between 1:200 and 1:400. This contrasts starkly with the availability of allopathic practitioners, for which the ratio is typically 1:20 000 or less (<http://www.who.int>).

TM is sometimes also the only affordable source of health care especially for the world's poorest patients. In Ghana, Kenya and Mali, research has shown that a course of pyrimethamine/ sulfadoxine antimalarials can cost several dollars. Yet per capita out-of-pocket health expenditure in Ghana and Kenya amounts to only around US\$ 6 per year (*ibid*).

Conversely, herbal medicines for treating malaria are considerably cheaper and may sometimes even be paid for in kind and/or according to the “wealth” of the client. TM is also highly popular in many developing countries because it is firmly embedded within wider belief systems (*ibid*).

2. Alternative approach to health care in developed countries

In many developed countries popular use of CAM is fuelled by concern about the adverse effects of chemical drugs, questioning of the approaches and assumptions of allopathic medicine, and greater public access to health information.

At the same time, longer life expectancy has brought with it increased risks of developing chronic, debilitating diseases such as heart disease, cancer, diabetes and mental disorders. For many patients, CAM appears to offer gentler means of managing such diseases than does allopathic medicine (*ibid*).

1.3.3 Uncritical enthusiasm versus uninformed scepticism

Many TM/CAM providers seek continued or increased recognition and support for their field. At the same time many allopathic medicine professionals, even those in countries with a strong history of TM, express strong reservations and often frank disbelief about the purported benefits of TM/CAM. Regulators wrestle with questions of safety and efficacy of traditional herbal medicines, while many industry groups and consumers resist any health policy developments that could limit access to TM/CAM therapies.

Reports of powerful immunostimulant effects for some traditional medicines raise hope among HIV-infected individuals, but others worry that the use of such “cures” will mislead people living with HIV/AIDS and delay treatment with “proven” therapies.

1.3.4 Challenges in developing TM/CAM potential

To maximize the potential of TM/CAM as a source of health care, a number of issues must first be tackled. They relate to: policy; safety; efficacy and quality; access; and rational use.

(a) Policy

According to WHO, relatively very few countries have developed a policy on TM and/or CAM. Only 25 of WHO's 191 Member States have a policy on TM and/or CAM. Yet such a policy provides a sound basis for defining the role of TM/CAM in national health care delivery, ensuring that the necessary regulatory and legal mechanisms are created for promoting and maintaining good practice, that access is equitable, and that the authenticity, safety and efficacy of therapies are assured. It can also help to ensure sufficient provision of financial resources for research, education and training.

(b) Safety, efficacy and quality: Crucial to extending TM/CAM

TM/CAM practices have developed within different cultures in different regions. Therefore, there has been no parallel development of standards and methods, either national or international, for evaluating them.

Evaluation of TM/CAM products is problematic. This is especially true of herbal medicines (*muti*), the effectiveness and quality of which can be influenced by numerous factors. Unsurprisingly, research into TM/CAM has been inadequate, resulting in paucity of data and inadequate development of methodology. This in turn has slowed development of regulation and legislation for TM/CAM.

According to WHO, many TM/CAM therapies have promising potential, and are increasingly used. Many of them are untested and their use not monitored. As a result, knowledge of their potential side-effects is limited. This makes identification of the safest and most effective therapies, and promotion of their rational use more difficult. If TM/CAM is to be promoted as a source of health care, efforts to promote its rational use, and identification of the safest and most effective therapies will be crucial.

(c) Access: making TM/CAM available and affordable

Although many populations in developing countries are reported as depending heavily on TM to help meet their health care needs, precise data are lacking. Quantitative research to ascertain levels of existing access (both financial and geographical) and extending such access, are called for.

Also, if access is to be increased substantially, the natural resources must be protected. Raw materials for herbal medicines, for instance, are sometimes over-harvested from wild plant populations.

(d) Rational use: ensuring appropriateness and cost-effectiveness

Rational use of TM/CAM has many aspects including: qualification and licensing of providers; proper use of products of assured quality; good communication between TM/CAM providers, allopathic practitioners and patients; and provision of scientific information. Challenges in education and training are twofold. Firstly, ensuring that the knowledge, qualification and training of TM/CAM providers are adequate.

Secondly, using training to ensure that TM/CAM providers and allopathic practitioners understand and appreciate the complementary of the types of health care they offer. Proper use of products of assured quality could also do much to reduce risks associated with TM/CAM products such as herbal medicines (*muti*).

1.3.5 Safety and efficacy issues

Scientific evidence from randomized clinical trials is only strong for many uses of acupuncture, some herbal medicines and for some of the manual therapies. Further research is needed to ascertain the efficacy and safety of several other practices and medicinal plants.

Unregulated or inappropriate use of traditional medicines and practices can have negative or dangerous effects.

For instance, the herb “Ma Huang” (Ephedra) is traditionally used in China to treat respiratory congestion. In the United States, the herb was marketed as a dietary aid, whose over dosage led to at least a dozen deaths, heart attacks and strokes.

In Belgium, at least 70 people required renal transplant or dialysis for interstitial fibrosis of the kidney after taking a herbal preparation made from the wrong species of plant as slimming treatment.

1.3.6 Biodiversity and sustainability

In addition to patient safety issues, there is the risk that a growing herbal market and its great commercial benefit might pose a threat to biodiversity through the over harvesting of the raw material for herbal medicines and other natural health care products. These practices, if not controlled, may lead to the extinction of endangered species and the destruction of natural habitats and resources.

Another related issue is that at present, the requirements for protection provided under international standards for patent law and by most national conventional patent laws are inadequate to protect traditional knowledge and biodiversity.

“To speak of ‘alternative’ medicine is . . . like talking about foreigners- both terms are very pejorative and refer to large, heterogenous categories defined by what they are not rather than by what they are” (Pietroni, 1992).

1.3.7 Tried and tested methods

25% of modern medicines are made from plants first used traditionally. Acupuncture has been proven effective in relieving postoperative pain, nausea during pregnancy, nausea and vomiting resulting from chemotherapy, and dental pain with extremely low side effects. It can also alleviate anxiety, panic disorders and insomnia.

Yoga can reduce asthma attacks while Tai Ji techniques can help the elderly reduce their fear of falls.

TM can also have impact on infectious diseases. For example, the Chinese herbal remedy *Artemisia annua*, used in China for almost 2000 years has been found to be effective against resistant malaria and could create a breakthrough in preventing almost one million deaths annually, most of them children, from severe malaria.

In South Africa, the Medical Research Council is conducting studies on the efficacy of the plant *Sutherlandia Microphylla* in treating AIDS patients. Traditionally used as a tonic, this plant may increase energy, appetite and body mass in people living with HIV.



Figure 1.21: A sangoma preparing muti



Figure 1.22: An inyanga selling muti

1.3.8 Communicable and Non-Communicable diseases

The HIV/AIDS epidemic poses an unprecedented challenge for Africa, reversing the gains made in life expectancy over the past half century. Life expectancy in the most severely affected countries has been reduced by almost a third, from 60 years to 43 years (<http://www.who.int>).

2.4 million people died from AIDS in 2002 and around 3.5 million new infections occurred. HIV prevalence in adults ranges from 1 per cent in some countries in North Africa to above 30 per cent in the high prevalence countries in Southern Africa, where it is estimated that economic growth has been slowed by 2.6%. The growing number of AIDS orphans starkly illustrates the social impact of HIV (*ibid*).

Examples are the 1 million deaths caused by malaria each year and the 600 000 deaths (on average 30-40 years prematurely) caused by tuberculosis. Malaria has slowed economic growth by 1.3% per annum at a \$12 billion economic cost. 34 countries have a tuberculosis burden exceeding the 300 per 100 000 population benchmark for severe disease, with 1.6 million new active cases occurring annually. Sleeping sickness is resurging, affecting between 300 000 and 500 000 people annually (*ibid*).

“You cannot fight an evil disease with sweet medicine.”
A popular saying amongst *inyangas*.



Figure 1.23: Urban muti market



Fig 1.24: Khekhekhe, famous *inyanga*



Fig 1.25: Some of the *muti* being sold

Table 1.1: Some of the countries that use TM

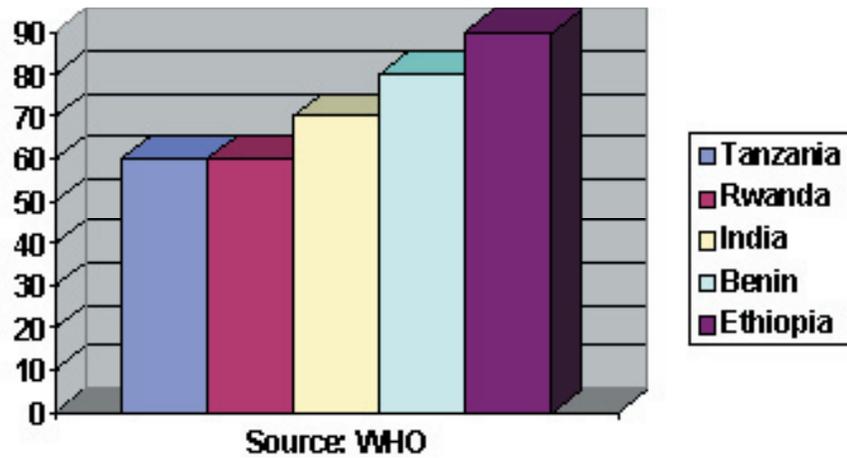


Table 1.2: Percentage of people who have used CAM at least once

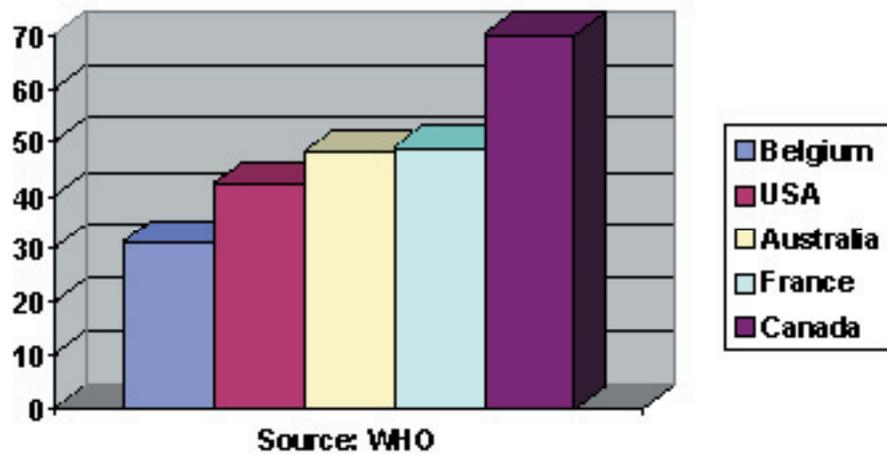


Figure 1.26: Emblem of NEPAD

1.4 The role of African Indigenous Churches

African Indigenous Churches played a major role among Africans especially during oppression. Europeans did not understand Africans and their culture when they brought Christianity into Africa. African Indigenous Churches combine Christianity with some elements of traditional African belief. Thus they are, in several significant ways, different from the mainstream Christian churches, brought to the Southern African subcontinent by European missionaries, that adhere to conventional Christian beliefs and practices. (<http://www.folklife.si.edu/resources/festival1997/faithin.htm>).

African Indigenous Churches filled a void that was created by the Western Churches. According to Reverent John S. Mbiti, African religions are older than both Islam and Christianity. Many books incorrectly speak of 'ancestor worship' to describe African religions. African religious activities chiefly focused upon the relationship between human beings and the departed (Mbiti 1969: 26). As Mbiti wrote, making sacrifices unto ancestors is "part of continuing fellowship not worship" (*Ibid*).

In the families fellowship with the ancestors is usually performed by the eldest member of the family. Such an act of worship can either be for immediate needs or simply inherited practise (Mbiti 1969: 58).



Fig 1.30: AmaNazarite during pilgrimage on mountains

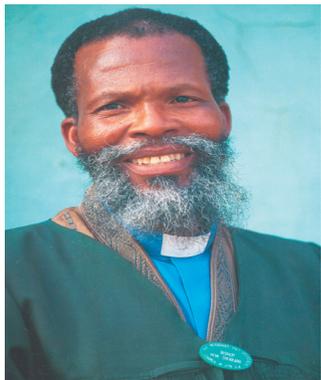


Fig 1.27: Bishop Sikakane of the Zionists Church



Fig 1.28: Amantobazana (Virgins)



Fig 1.29 : Zionists during prayer



Fig 1.31: Zionists during church service

1.4.1 Zion Christian Church (ZCC)

ZCC is the largest and fastest growing of the African indigenous churches in South Africa. The church members, estimated to be between 2 million and 6 million in 4000 parishes, live primarily in urban townships and rural areas. The ZCC was established in 1910 by Engenas Lekganyane, a farm worker in the area that was later to become Zion City (Moria), in Limpopo Province. The ZCC took its name from Biblical references to the mount of Zion in Jerusalem, based in part on the inspiration of a similar community in Zion, Illinois (http://countrystudies.us/south_africa/54.htm).

The growth of African Indigenous Churches was spurred by the anti-apartheid movement. The Zionist churches did not break away directly from the mission establishment; their origins lie, instead, in Zion City, Illinois, where John Alexander Dowie (1847-1907) founded the Christian Catholic Apostolic Church in 1896. The influence of his church spread to South Africa in 1904 when Daniel Bryant baptized several Africans (<http://www.folklife.si.edu/resources/festival1997/faithin.htm>).

The ZCC respects traditional African religious beliefs, in general, especially those concerning the power of the ancestors to intercede on behalf of humans. As a Zionist organization, the ZCC is characterized by an emphasis on divine and faith healing, purification rites, dancing, night communion, river baptism, the holy spirit, taboos, and prophesying and so on (*ibid*).

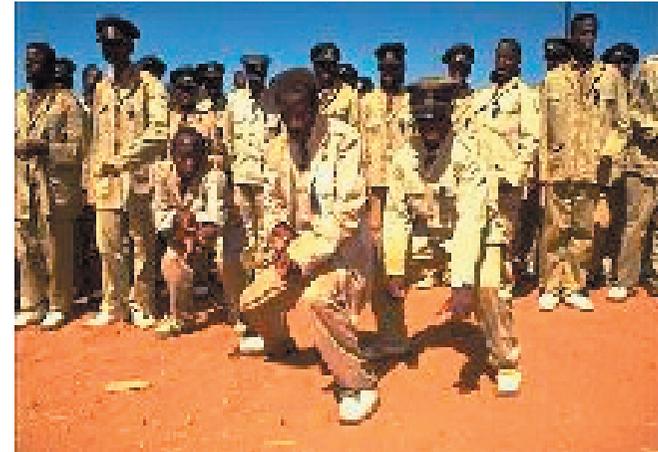


Figure 1.32: Mokhukhu (ZCC male dancers) in action

1.4.2 Nazareth Baptist Church (*Ibandla lama Nazareth*)

The *amaNazarites* of Isaiah Shembe are the oldest African Independent/Indigenous Church in South Africa. The church divided into two main sections in 1976 following the death of its leader and founder Bishop Johannes Galilee Shembe [1904-1976]. The largest group was led by Bishop Amos Shembe [1907-1996], the other, smaller group, by the Rt. Rev. Londa Shembe [1944-1989] (<http://www.ucalgary.ca/books/shembe.htm>).

Mbusi Vimbeni Shembe, successor of Bishop Amos Shembe, is the current leader of the major branch with over a million *amaNazarites*, most of whom are Zulus. His great grandfather was a great diviner who healed the people, even those of the royal family. The church is based in KwaZulu-Natal and have their pilgrimage on the mountains (*ibid*).

1.33



1.34



1.35



Figures 1.33-1.35: AmaNazareth during pilgrimage in KwaZulu-Natal

1.4.3 Healing and prosperity as a growth factor

The main reason people joined African Indigenous Churches in the early years was healing from sicknesses. Because of the significant number of second generation Christians now in this churches, the ongoing healing offered to these members in fact makes healing one of the most important factors in its continued expansion.

People continue to join these churches because they believe their needs are met, this include healing from sicknesses and discomfort. Majority of black people are living in the townships and rural areas, and often times efficient medical facilities are expensive and scarce. Therefore, consulting a priest for healing remain the only option available for many.

Priests in different Indigenous Churches heal sick people differently. Some priests would lay their hands on a sick person and pray over him/her. Some of the priests would give a sick person 'holy water' to drink. Some priests can even encourage a sick person to consult a traditional healer if they are unable to heal him/her. Some priests can even advice a sick person to slaughter an animal to the ancestors to please them.

Some people join these churches because they believe they will be delivered from the curses and be blessed. They believe that their problems will disappear for good. Many people believe that joining these churches will guarantee their prosperity. Therefore, people will obey every word that is spoken by the priests. After all, they are God's representatives on earth and they are able to communicate with the ancestors directly. Hence, people believe that misfortune will come to anyone disobeying the priests and prophets.

"Man stands apart from all other creatures not only as a tool-maker and word-maker, but also as a worshipper and temple builder as well." (Mirsty 1965: 1).

1.5 Traditional Circumcision

“The most widespread form of bodily mutilation is male circumcision”
(<http://africanvoices.co.za/circumcision>)

Ritual circumcision is practised across many cultures in the world and is one of the “most resilient of all traditional African practices within [the] urban industrialised environment” (*ibid*). Every year hundreds of young *abakhetwa* (Xhosa: male initiates) in the Eastern Cape undergo traditional rites to become *amadoda* (men) and to honour their forefathers.

Ritual circumcision under some circumstances can put young *abakhetwa* at risk of contracting STD's, HIV/AIDS and other blood-borne infections. Therefore, traditional surgeons (*ingcibi*) need to be taught safe ways to circumcise the initiates. Hence workshops will be run at Dingakeng Centre to keep traditional surgeons informed about the latest safety measures.

For Xhosa-speaking people who practice ritual circumcision as a cultural institution, alternatives are negligible to non-existent. Initiation is seen as the “formal incorporation of males into Xhosa religious and tribal life”, and before circumcision, a male cannot marry or start a family, inherit possessions, nor officiate in ritual ceremonies. Young who have been to initiation school are distinguishable by their social behaviour and a particular vocabulary they learn during their time in the bush (*ibid*).

During his presentation on the provincial conference on circumcision on the 27th September 2004, the Eastern Cape MEC for Health Mr Bevan Goqwana said that “this custom was practiced by our forefathers and has been in existence from time immemorial, and has been passed on from one generation to another”. He also highlighted that circumcision reduces the chances of being infected with the HIV virus. In 2001 the government passed the Traditional Circumcision Act of 2001 in order to regulate the practice and to avoid botched circumcisions (<http://www.ecprov.co.za>).

Circumcision has been practiced for many generations in different parts of the world either as part of culture or religion. For example, both Jews and Muslims practice male circumcision. Circumcision is one of the strictly observed religious practices in the world. Often, Muslim boys pass through their major status change - circumcision (khitan) when they have recited the entire Qur'an [Koran] once through. Boys are usually circumcised once they are between the ages of ten and twelve years old (<http://wwwm.circlist.com/rites/moslem.html>).

Ritual circumcision becomes a health issue when certain problems/factors arise. These can be attributed to the following five factors:

- 1) The training and competence of the traditional surgeon (*ingcibi*) Inadequate training can lead to errors in surgical technique, and at times, surgeons have been found to be operating under the influence of alcohol.
- 2) The sterility and reuse of surgical instruments Traditionally an *assegai* is used. Implements may be blunt or reused. This practice has been implicated in the spread of blood-borne infections, such as Tetanus, Hepatitis B and STDs, including HIV/AIDS. As yet, no study of HIV/AIDS in relation to ritual circumcision has been carried out, as youths presenting at hospitals are not routinely tested.
- 3) STDs among the *abakhetwa*. Traditionally, sex was proscribed before marriage, however, youth are becoming sexually active at an increasingly younger age and therefore there is a higher prevalence of STDs amongst initiates. This is transmitted through the use of equipment that is not sterilised between each use.

4) Aftercare Medical complications occur most frequently during the aftercare period of the initiate. A traditional attendant (*ikhankatha*) is ascribed to each initiate, and is responsible for bandaging the wound. Ischaemia (starvation of blood supply) or/and infection from the tight thong bandage wrapped around the wound, leads to penile sepsis and gangrene, with subsequent loss of penile tissue. Infection can spread throughout the body and ultimately, Septicaemia is the cause of most deaths from circumcision (<http://africanvoices.co.za/circumcision>)

5) Another risk factor is severe dehydration, which is common in initiation schools, because initiates are discouraged from drinking fluid post circumcision. This is not only to prevent frequent urination, but is set as a test of endurance. This taboo, accompanied by climatic factors - initiation schools currently occur more often in the hot summer months, as opposed to autumn in the past - and the use of plastic building materials in lieu of traditional grass and leaves, contribute to a harsh environment that is not conducive to healing (*ibid*).



Figure 1.36: Abakhetwa (male initiates)



Figure 1.37: Muslim boy is circumcised

1.6 The brief

The state of traditional health practice is in chaos because it went for some time in the past without being regulated by the authorities. The *inyangas* and *sangomas* were practicing without proper documents and were not recognised by the apartheid regime. Since traditional health practice was not regulated, patients with complaints did not know where to lay their complaints. Since genuine *inyangas* and *sangomas* were practicing without certificates, it was difficult to know who is a fake and who is genuine.

According to the Traditional Health Practitioners Bill (2003), traditional health practitioners are required to have a valid certificate before they can practise (<http://www.doh.gov.za/bills>). Unfortunately, there are still a number of traditional healers practicing without the relevant certificate. As a result, this has led to malpractice in other areas.

Another problem is that majority of the *inyangas* and *sangomas* practice mainly in rural areas and it is difficult for people in urban areas to access them. Therefore, people in the cities have to spend more money to consult either an *inyanga* and/or a *sangoma*. Unlike medical doctors who have facilities like hospitals and clinics, traditional healers do not have any facilities where they can practice their medicine. Hence, most of the *inyangas* and *sangomas* practice their medicine in their houses.

The Western medical doctors have always undermined traditional healers. Since there is always been secrecy surrounding the practice of traditional medicine, Western medical doctors labelled it as being magic and witchcraft.

There is not a good relationship between traditional and Western medical practitioners at the moment.

The new centre will encourage good working relationship between both the Traditional and Western medical practitioners. Any stereotypes about each other will be eliminated. The centre will be a model that both Traditional and Western practitioners can work together. Patients with medical aids will not be forced to go to hospitals; they have the option of consulting *inyangas* and *sangomas* using medical aids.

On the 6th of June 2006, the Minister of Health Manto Tshabalala-Msimang, said that traditional medicine will soon be recognised in the health budget. Speaking at a traditional medicine workshop in Benoni, Tshabalala-Msimang also said her department would speed up the process of establishing an interim traditional health council (www.doh.gov.za/docs/news)

Tshabalala-Msimang said: "There is a great deal of literature on traditional medicine in India, the Philippines and China. We need to establish this for African medicine." She also said developing countries were appreciating the value of traditional medicines and alternative practices, pointing out that Britain's Prince Charles had been a supporter of the concept (*ibid*).

Therefore, since the traditional medicine is going to be recognised in the health budget, to design a facility where traditional health practitioners will practice. The *inyangas* and *sangomas* who will practice in the centre will possess a certificate to comply with the Traditional Health Practitioners' Bill (2003).