

Reinforcing Indigenous Communal Healing (ICH) as a Sustainable Health Science and Practice in Africa

“Indigenous evidence-based practice”

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Abstract

There has been a gap in the scientific nature of health sciences in indigenous communities for a long time (WHO, 2013) and colonial-hegemony still enjoys centre-stage in Africa's health delivery system. Without acknowledging its efficacy, indigenous healing is generally depicted in the daily discourse of highly appreciated and regarded African scholars in utterances like “African Indigenous Knowledge must be proven scientifically” or “The research on indigenous knowledge systems must be reviewed by a virologist (‘real scientist’) to ascertain its scientific and scholarly rigor”. The previous dialogue generally invites a senseless cacophony where western-dominant scientists critique classical African scientific work through western science lenses without considering the unique African scientific domain. Hence their repressive assertions on what constitutes sciences. Contrary to what my elongated experience as an African indigenous scholar has revealed, it is noted that being African is currently viewed as a fashionable label, rather than an authentic lifestyle. However, the mentioned label occurs without the appreciation of the full amour of Africaness, Africanology or Africanity if new terms are to be coined to express one's being unreservedly African in deeds and spirit despite the potential backlash. Evidently this longitudinal research executed by the Seboka research team elicit a critical scholarly discourse led by trigger questions to reinforce African Indigenous Communal healing as a health science and practice in its own right.

Keywords: African, indeginous, communal healing, health science

Introduction

It is disheartening to note that amidst indubitably and undoubted evidence that indigenous healing is universally used around the globe for numerous reasons known to the indigenous community (WHO, 2013), colonial hegemony still enjoys centre-stage in Africa's health delivery system. Without acknowledging its efficacy, indigenous healing is generally depicted in the daily discourse of highly appreciated and regarded African scholars in utterances like "African Indigenous Knowledge must be proven scientifically" or "The research on indigenous knowledge systems must be reviewed by a virologist ('real scientist') to ascertain its scientific and scholarly rigor". The previous dialogue generally invites a senseless cacophony where western-dominant scientists critique classical.

African scientific work through western science lenses without considering the unique African scientific domain. Hence their repressive assertions on what constitutes sciences. Mapara (2017:1) refers to such misplaced research views and practices as "lukewarm research into indigenous knowledge systems" Definitely a correct evaluation for western research, but uttered on the wrong platform. *Whose evidence and sciences are we talking about?* And when people march for science on Earth Day, whose science are they marching for? Is it not the entrenchment of hegemony of only western science as the only science? A science not in service of humanity but of individuals' financial benefit?

Contrary to what my prolonged experience as an African indigenous scholar has revealed, it is noted that being African is currently viewed as a fashionable label, rather than an authentic lifestyle. However, the mentioned label occurs without the appreciation of the full armour of Africaness, Africanology or Africainity if new terms are to be coined to express one's being unreservedly African in deeds and spirit despite the potential backlash. Most scholars like Green (2012) claim to be African or write from Africa, but sadly only a few are prepared to uphold the order of a genuine African phenomenon. Therefore, it is generally complex for most western-dominant African scholars to accept that African Indigenous Knowledge System (AIKS) is a science in its own right, without the need to be authenticated by western sciences as Green suggests when he makes reference to India (2012, 1). What further fuels this is the fact that most African scholars continue to serve this denialism against African indigenous sciences backed by an eloquent and intransigent colonial hegemonic perception and drive.

On the other hand, it is common knowledge and practice that Africans through their governments promote several health declarations and promulgate them as policies in their health systems. These have their genesis in promulgations such as the Alma Ata Declaration (1978) that was instituted to promote primary health care as a valuable health approach and the Millennium Development Goals - MDGs (2015) that dismally failed according to the 2015 report and now the Sustainable Development Goals (2015) where it is clearly stated that the health care must be community centred, meaning that it must be the community's choice. However, and tragically, most Africans still remain in denial and are unmoved by this reality.

In endeavours to counter this denialism of African Indigenous sciences some African indigenous scholars are currently embarking on an educational journey to relearn the science domain in Africa. An example of such a journey that has been embarked on can be seen in works like the book edited by Ngulube (2017), *Handbook of Research on Theoretical Perspectives on Indigenous Knowledge Systems in Developing Countries*. Further contributions to the African science domain is the deliberate development of African indigenous research methodologies namely the use of the Lekgotla in data-collection (Pienaar, 2013) and "Learning and Asserting an African Indigenous Health Research Framework" (Pienaar, 2017).

Subsequently this paper aims to elicit a critical scholarly discourse led by trigger questions to reinforce African Indigenous Communal healing as a health science and practice in its own right.

Methodology

The researchers applied a Desk Research Review to collect secondary data from all the research completed by the Seboka Research Team from 2008 to 2017 and other applicable literature to illuminate the discourse at hand (Whitehead, 2005). According to Whitehead (2005) Desk Research refers to secondary data or information that can be collected without fieldwork. The mentioned method is frequently carried out where the data exist and if it is the most cost-effective method. For the discourse in this paper the primary data obtained through research existed already.

Purpose of the Review

The purpose of this review was to demystify learned myths that African indigenous knowledge is not a science by revitalizing the African science domain as well as to reinforce Indigenous communal healing as a science in Africa. The Desk Research Review endeavoured to:

- Demystify the meaning of the concept science;
- Illustrate the scientific revitalization of African indigenous sciences in healing;
- Apply the competences of practitioners in African Indigenous knowledge to promote inclusive health care;
- Critically discourse the state of colonial hegemony as a stumbling-block amongst African scholars; and to
- Reinforce Indigenous Communal Healing in Africa as a sustainable health science and practice.

Is African Indigenous Knowledge Systems a Science

The Meaning of Science

To foreground this review, a baseline concept analysis of the concept science is fundamental and is thus presented. Scholars need to understand the meaning of 'science' in order to comprehend that African Indigenous Knowledge is a science in its own right. Therefore, science practice in this domain should be judged through the lenses of African Scientific phenomena, and not from a western science perspective.

Science as a neutral concept originates from the Latin word *Scientia*, which means knowledge, skills or competence (Merriam-Webster Dictionary, 2017; Online Dictionary, 2017). Ironically noted is that this concept *Scientia* is an abstract feminine concept, whatever this assertion might elicit in the mind of an innovative scholar. It is therefore safe to deduce that the degree B.Sc. (from Latin *Baccalaureate Scientia*), means an undergraduate degree in knowledge, skills and/or competence hence the qualifier B.Sc (Chemistry). Thus the candidate obtains basic knowledge in chemistry.

Furthermore, the concept science is defined by *Oxford Dictionary* (2017) as the logical manner to generate knowledge through *identification, observation, experimentation and theory generation*. Additionally, science is also described as a practice to

acquire knowledge gained from general truths in a particular field whereas others depict it as a body of knowledge within a specific domain or a practical and or intellectual activity accompanied by logic and systematic reasoning (*Business Dictionary*, 2017). The core of the definition of the concept science is therefore knowledge, skills and competencies that are acquired through specific logical methods within a particular phenomenon or field. Nowhere is it stated in this analysis that African Indigenous Sciences must be acquired through western chemistry, physics or health practices and manners. Neither does this neutral comprehension state that western natural, social or health sciences should set the rules or methods for African Indigenous Sciences or those of any other people in other parts of the world. However, shallow scholarly statements as stated in the introduction assume paternalistic responsibility over African Indigenous Sciences. Clearly a spontaneous question should be asked "Who and what gave you authority over this sacred science domain?" Unless we place and respect African Indigenous Sciences in its original domain, scholarly engagement about this domain can become a futile exercise characterised by counter-narratives and discourses which deny us the opportunity to benefit from not only the diversity of humanity but also of the sciences that we generate.

With all due respect, it is further essential and imperative to understand that science is built on a belief (Pienaar, 2017). Scientists cannot understand geometry and the theorems in geometry when they do not accept and believe in an axiom, e.g. that a straight line is 180 degrees. Geometry as a science is built from an axiom, a basic concept with no specific meaning than just a belief. Axioms form statements and statements in turn form theorems, e.g. the theorem of Pythagoras. Equally so in the theological sciences of Christianity, the belief that Maria was impregnated by the Holy Spirit is fundamental to the belief and practice of a Christian. Hence the reproductive sciences of midwifery become irrelevant in the science domain of Christianity. Therefore, in realizing the uniqueness of each science domain it must be noted that it will be difficult to believe and practice African Indigenous sciences without the comprehension of basic principles in this phenomenon, e.g. consultation with those who were on earth before us (fore-parents).

In further engagement with the roots of most scientific domains, we appreciate that all sciences started in the meta-physical domain which is mostly beyond human comprehension. Noteworthy to mention is that the chemistry periodic table started with a dream and evolved through engagement with the dream to unfold further in the chemistry the periodic table and its modern scientific mutations.

Why is African indigenous healing scientific?

Scientific Revitalization of African Indigenous Sciences in Healing

The first formal conceptualization that underpinned African Indigenous Knowledge as a science started with the doctoral research, *The Development of an HIV/AIDS Counselling Approach for Africans*, (Pienaar, 2005, Pienaar & Uys, 2013). In this thesis the researcher found that the HIV/AIDS counselling approach prescribed by most western schools of thought is counselling that could rather be classified as an information session or health educational session and that Africans indeed have a different approach to counselling. The African approach of counselling is based on three anchors “*Ke phela bophela baka* - I live my life”; the second anchor is “*Bophelo ke thlakantsu ya monate le bosula* - Life is a bitter-sweet mixture” and the third anchor is “*Motho ke motho ka batho ba bangwe* - I am, because you are”. The counsellor uses indigenous listening and probing techniques, including spiritual and emotional techniques in this counselling approach. Through the years of application it is noted that African indigenous mental health care users experience more care and cultural congruent respect. During the same time a chapter was published to illuminate African indigenous concepts in health (Pienaar & Manaka-Mkwanazi, 2004). These two contributions formed the foundation for the concept and practice of indigenous health in some African countries.

The previous foundational work led to the successful application of the first collaborative Indigenous Knowledge Systems project for funding, which in return gave birth to a prescribed textbook, *Mental Health in Africa: An Evidence-Based Approach* (Pienaar, 2013). The author utilized his own research as well as evidence-based research of the eight master’s- and one honours students he supervised from 2010-2013 and collaborated with several western grounded researchers to publish the first work for educational purposes that advocates for the co-existence of African indigenous and Western health practices in mental health. This prescribed textbook is prescribed across the African continent.

During the research process of the post-graduate supervision, the researcher made use of cohort research supervision for the first time (2008-2010), where there was constant peer-group support and evaluation amongst the post-graduate students. This process is currently maturing in the Seboka team that the researcher leads. The cohort supervision spiralled out to the involvement of

the community, other researchers and post-graduate students. Currently it is common practice for post-graduate students who join the Seboka team to gain support from their peer group, senior post-graduate students and other collaborative researchers, as well as the community who moderates the outcome. This is a unique strategy of learning, deduced from the apprenticeship of African indigenous healing (*ukuthwasa*) that strengthens community engagement, education and research in the Seboka team.

Further research was done in African indigenous health, with specific reference to medicinal plant analysis, indigenous health practices and other broader indigenous health issues from 2007 to date. The follow-up research themes in the projects funded by the National Research Foundation and the Department of Science and Technology is the Revitalization of an existing African Primal/Primordial Health Care system in rural South Africa with specific reference to including the practice and medicine (2013-2016) as well as the current project “The Development of an African Indigenous Framework for Community Engagement, Education and Research” (AIHCER) with a follow-up in the establishment of the AIHCER theory. It is noteworthy to mention that the full process of the scholarly work focuses on long-term theory generation to establish a robust theory for African Indigenous Community Engagement, Education and Research (AIHCER) that can be built as a foundation to expand this body of knowledge in IKS. Several post-graduate students have done valuable research contributions since 2008.

Except for publications that can be used in clinical health science education, other publications that contribute to this body of knowledge are the development of research methodology and African indigenous methodology in qualitative research, (Pienaar, 2014). This methodology is broadly used for post-graduate research data-collection, especially in South Africa. The NRF commended the researcher in their review report (NRF, 2014) for the contribution in research methodology. Further methodological research is the contribution in Handbook of Research on Theoretical Perspectives on Indigenous Knowledge Systems in Developing Countries which are published as chapters four and sixteen (Pienaar, 2017; Mphuthi & Pienaar, 2017). This was an international contribution in indigenous knowledge systems.

It is worth noting that the researcher in his scholarly endeavours since 2001 has contributed and is still contributing to the broader Indigenous Knowledge Systems discourse and specifically to indigenous health sciences and community engagement (Pienaar, 2017), education (Pienaar, 2013) and research (Pienaar 2014 and Pienaar, 2017). Through his active engagements, innovative

discoveries, leading to community co-owned patents are in the pipeline through the collective scholarly work of the Seboka team and the researcher (Seboka, 2015). The research journey of this scholar is truly based on the African philosophy of I am, because you are, including of family, the community and the broader academic community, specifically the post-graduate students who worked and are still working with the researcher.

Case Study to Promote Inclusive Health Care: A Class Room Application

“Professor, when a mental health care user (of indigenous African origin) is psychotic, admitted in a mental health care establishment and the family would like to take him to a *sangoma*, the ‘purging type’, should I protect this mental health care user against the request of the family?’ In my role as a mental health care nurse, what should I do, because I am supposed to advocate for the mental health care user to receive quality mental health care?”

(Third year student of African origin)

Why is an African student questioning the indigenous health care system in Africa?

Zuyderduin, Pienaar & Bereda-Thakathi (2016) argued in their article that the educational system for nurses as lead health care professionals in Africa is predominantly based on the western educational system. This western-dominant education in Africa disadvantages the African health care users from an inclusive health care system that also recognises and respects the existence and practice of an African Indigenous System. Therefore western health care practitioners in Africa should relearn the significance of the African indigenous health care system and unlearn to judge this system without evidence.

Learning points in this case-study:

Western Health lenses:

The mental health care user is psychotic, therefore admitted as an involuntary mental health care user According to the Mental Health Care Act, therefore the rights of the health care user are seized and effectively cease to exist.

The mental health care user admitted is under the influence of psychotropic drugs (major tranquilizers) that have adverse side-effects like tardive dyskinesia and akathisia, therefore appearing ‘drunk’. The intervention therefore might be the addition of psychotropic medicine (anti-parkinsonism) to counter the side-effects (more medicine), that will cause more drowsiness.

Other intervention is reality orientation and psycho-education (support) until the health care user becomes used (addicted) to the levels of drug intoxication. This is a bad cycle of adding more and more medication and therefore enriches western-based pharmaceutical industries. Unfortunately, this can continue until death.

African Indigenous health lenses:

How do the family and an African Indigenous health practitioner view the current health challenges of the health care user? This person is medicated and has visible side effects, that make them look more drunk amongst other psychotic mental health care users, all together worsening the healing perspectives of their family.

Noting the state of the family member in the hospital (appearing intoxicated/drunken) immediately brings forward the conclusion that the health care user is intoxicated - took too much of a certain substance, therefore needs cleansing.

The choice of the healer would then be the ‘purging type’ to induce vomiting for internal cleansing. This is a process of internal cleansing or detoxification to alleviate the health care user of the excessive substance/ overdose

An intervention is therefore the use of an indigenous enema (*sipyi*) or emetic plant medicine to induce vomiting (*gokapa*) to promote internal cleansing to get rid of the toxins.

Insights to promote inclusive health care delivery:

The indigenous health team is collectively involved (family, healer) and see the health care user as intoxicated (poisoned) by the western medicine. Therefore, the first intervention that is needed is cleansing through a process of “*gokapa* (induced vomiting) and *sipyi* (indigenous enema)”

Subsequently a similar practice in western health care is done when the health care user takes an overdose of a substance either by attempting suicide or by mistake, in the case of a minor. The western practice is to provide intravenous therapy (internal

cleansing) and emetic medicine to induce vomiting to get rid of the excessive substance;

Basic Lesson - Same practice in different contexts, however – it is acceptable if it is labelled in the western context and done in a western health care establishment by western- trained health care providers.

Salient *derogatory concepts* were built into the health care jargon in colonized Africa to discredit the indigenous health care system, e.g. healer vs witchdoctor ‘purging type healer’ versus the provision of an emetic in this case; gastric lavage (western) which is the same as the manual relief system ‘spyt’; home-based-care and community health care versus primordial/primal or communal health care; midwife-led home-based care deliveries versus ‘traditional birth attendants’. Language became and still remains a weapon to disempower the African indigenous health care system, but in the meantime we overlook the theft that took place in the health care system in Africa. Africans managed most of their health care challenges at home collectively with the family, community and the healers (communal health). However, the western curative health care system necessitated hospitalization for the sick. Years after the institutionalization of the sick, a number of health care approaches, taking the sick back into the community is proposed by the western health care system totally repackaged as ‘primary health care re-engineering’. *Is this not a white-collar crime? Academic theft and piracy?*

Worth mentioning is the fact that labelling is generally chosen for Africans in a colonised system. Like a witch-doctor, instead of healer; traditional birth attendant instead of an indigenous midwife. Therefore, the health care delivery system becomes questionable without a fair and just interrogation when it is done in an African Indigenous Health care team.

A basic skill for a western trained practitioner is to explore, listen and negotiate the co-existence for an inclusive health care delivery.

What is prohibiting Africans to comprehend their indigenous health beliefs and practices?

The State of Colonial Hegemony as a Stumbling-Block Amongst African Scholars

The colonial hegemony that has continued unabated was certainly engineered by the past social injustices towards the African indigenous health care practices and seems to be ingrained in Africans of today, including those generations that did not live during this era. This is very clear when we focus on the system of colonial supremacy in South Africa where the previous political convictions, legislation, educational system and religious practices in general were anti-Africans. These political convictions were enshrined in the policies of the oppressive apartheid government, introduced in 1948, where Africans had minimal or no rights. This was further fuelled by the legislations like the Witchcraft Suppression Act no. 3 of 1957 that aimed at eradicating the indigenous health care practice in South Africa against the so-called supernatural means of healing and the witch-doctor (indigenous healer). Although the Traditional Medicines Act No 22 of 2007 was promulgated by the president, there is no evidence that the Witchcraft Suppression Act no. 3 of 1957 was repealed. It might therefore still pose a threat to the authentic practice of African indigenous healing practices

Adding to the legislation were the day-to-day practices, like the educational system that was closely monitored for contravention of the oppressive laws of the country and riddled with religious practices that benefitted the government of the day. It was common practice that the curriculum was filled with biblical or religious studies and more often than not Africans were prohibited to do subjects like mathematics and science. Therefore, the fear for these subject fields continues today where parents advise their children to refrain from these difficult subjects. This was meticulously engineered to de-culturalize the African race in Africa. However, as much as some consequences that are still prevailing, this is viewed as the past in South Africa. The current government endeavoured to change all oppressive and corrosive policies.

Current policies foregrounding the government of the day are the Reconstruction and Development Policy of 1994 and South Africa’s famous Constitution promulgated in 1996. When one peruses these policy documents you are convinced that freedom of expression and of freedom of choice, specifically to the choice of health care must prevail. Furthermore the Traditional Medicines Act No 22 of 2007 also regulates the legal freedom of African indigenous health care in South Africa. Supporting this

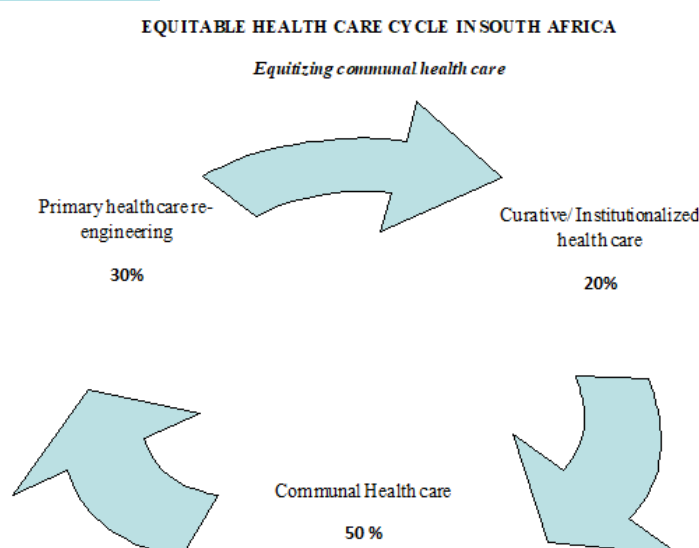
political and legal regulations are the global and national policies on the evolution of health care. These policies are the Alma Ata Declaration of 1978, the Ottawa Declaration on Health Promotion, the WHO on Indigenous Health, the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs) and the South African Health Strategy 2014-2019. Why are these policies not winning in uplifting the health care of Africans? By comparing and contrasting these policies the main aim is to promote respect and acceptance for quality health care for all. Subsequently these policies advocate for the inclusion of indigenous communities in health care delivery to accomplish a healthy community, including the choices of health care, which is why India and China are leaders in the co-existence of various health care systems. Unfortunately, the choice or even the inclusion of indigenous health care is not promoted candidly in Africa. Despite the overt oppression of the African Indigenous Health Care System, it has stood the test of time (Pienaar, 2017). Hence we need to ask: “*What is the challenge in Africa?*”

Potentiating health care challenges is the fact that Africa is currently entering an aid threat when it comes to health care delivery. The assertion of the past president of the United States of America, Barack Hussein Obama, that Africans should stop standing with open hands and start relying on themselves invited heavy criticism from especially African leaders. However, this declaration is realized by the constant threats of the current president, Trump, who plans to reduce aid to Africa. A spontaneous question arises: What will happen to the HIV and AIDS treatment in Africa that is largely funded from America? Conversely, it is noted that 80% of Africa's flora has medicinal properties and research in this direction is growing exponentially. But a serious challenge threatens the good work, namely colonial hegemony.

It is common cause that influential South Africans are captured within the colonial hegemony, which stems from 1948. Colonial hegemony is a state where the previous imposed regulations and practices of the colonialist calibrated the being or psyche of the African human race to act within colonial regulatory and dogmatic boundaries, even when colonial oppression is long defeated. Furthermore, a colonial hegemony is an institutionalization of the spirit, mind and insight of Africans as the backward other that can only be taught to learn to become a second rate European, but will always remain sub-standard and a poor cousin of the European, who is the real human being (Kipling, 1899). It is characterized by a state of spiritual, mental and physical helplessness, even when the oppressor leaves; the formerly oppressed continues to function within the constraints of the oppressive regime. Therefore, the oppressed becomes the oppressor; hence healing is also needed in this regard. All regulations in the South African health arena have changed. We need to fight for equity in health, because equality will disenfranchise us further. Because in an equal system, those who had more, gain more and it keeps them ahead of the others. Let us take hands, not to disregard the effectiveness of the western health care system, but to explore the benefits of the African indigenous health system which has sustained generations so as to safeguard ourselves from a brewing health catastrophe.

With this critical discourse it is recommended that African indigenous communal health care, also known as primal or primordial health care take centre stage and leads the way for primary health care re-engineering in South Africa. This is a care where health care starts with the interventions of the family, moves to the neighbours (community) and then to the healer (expert health practitioner). In this process and practice, all stakeholders take responsibility for the healing process to take place.

How can we restore the equity in health care?



In this it is proposed that communal health care is equitized, and therefore given more resources to actively function in the health care system, supported by primary health care in the community. This primary health care therefore is not the umbrella health care, but a co-health care system in the community. Furthermore, less is invested in curative or institutionalised health care, because rehabilitation and end of life health care can still take place in the community setting. It is proven beyond denial that more than 80% of Africans make use of indigenous or natural health care in South Africa and this health care system has been and continues to be effective and successful. Further regulatory and practice issues are covered in the unfolding legalization of indigenous health care in South Africa.

Evidently the WHO-Traditional Medicine (TM) strategy emphasizes that indigenous medicine is readily accessible, it's situated in the community and affordable (WHO, 2013). The WHO- TM strategy links perfectly with the Primary Health Care re-engineering strategy of South Africa, because the PHC-re-engineering is to strengthen district health services (DHS), simultaneously strengthening community health services to do the basics better (National Department of Health, 2011). Hence this advocacy for the repositioning of African Indigenous Communal Health care where the community takes responsibility of each other's healing. In this set-up as already indicated, the family and community are actively involved in the healing process with the indigenous healer as an expert guiding the healing process. Therefore, it is recommended that African indigenous communal

health care is brought to an equitable level with the western health care system, where indigenous communal healing receives an equitable share of the health care budget in Africa. In such a set-up, families should also be given a voice so that they choose where they can take their loved one for care and healing.

The reinforcing of indigenous communal health care supports the National Health Strategy of South Africa (2014-2019) where the aim is to make health care more accessible, equitable, efficient, quality and sustainable. Communal health care starts in the family, moves to the community and then to the health care providers. These stakeholders work collectively to facilitate healing. Manifestly indigenous communal healing is the best option to strengthen district health services.

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