

The use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia

by

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ABSTRACT

The thesis examines mental illness as it is understood and treated by traditional healers in Kavango, based on ethnographic data collected over twelve (12) months in three (3) different phases from 2014 to 2016. The thesis offers ethnographic material and theoretical insight on the socio-cultural construction of three common mental disorders (CMD) which were identified and treated by traditional healers: *Nyambi*, *Kasenge* and *Ndjangura*. I employed the ‘cultural models’ of Dahlberg et al (2010, p. 282) as a framework to understand mental illness and its treatment by traditional healers - who deal with sick persons on a daily basis. The three common mentally related illnesses appear to be specific to the Kavango people, based on their cultural settings. I argue that these mental illness categories are not fixed or objective, but rather reflect the expertise of the *Vanganga* (Traditional healers) who identify them, and ultimately treat the afflicted. While traditional healers themselves assume that these local notions of mental illness are static, in reality they are not. Rather, these are active concepts constituted by culturally and socially relative categories whose precise boundaries and meanings vary and are highly contested. It was evident that the conceptualization (expression of belief patterns, thoughts and ideas) by the *Vanganga* (Traditional healers) of the three local mentally related illnesses differed, in the ways they perceived and treated similar conditions. The manner in which these perceived signs and symptoms informed their diagnoses differed, but also overlapped: in terms of basic assumptions that underlay explanations and treatment, and the ways in which the conditions became manifest. The thesis postulates that Traditional healers form part of the local health care system, historically unregulated. There have been calls for the recognition and regulation of traditional healers and their medicines, but to date such recognition and regulation has, if anything, been sporadic, insufficient and controversial. In response to this I provide a new way of classifying traditional healers in Kavango and propose the use of three categories: *Kangangwena* (assistant traditional healer), *Nganga* (general traditional healer) and *Nkurunganga* (expert traditional healer). The thesis discusses the cultural epistemology of traditional healing concerning the use of medicinal plants as treatment for mental illness. Plant knowledge and its application by traditional healers is explored, with the emphasis on the medicinal plants used to treat various mentally related illnesses. In addition, administration methods and the medicinal plants used in the treatment of mental illness are examined. I argue

that medicinal plants are believed to possess powers that need to be “enticed or seduced” by healers, in order to produce a therapeutic effect on the *muveri* (sick person). I contend that medicinal plants are perceived to have an agentivity which is embedded in the community and people who utilize them. Thus, I intend to show that medicinal plants have power that work at different levels via ritual healing ceremonies and communication to the ancestors, as a way of “seducing” them to bring forth their therapeutic effect on the sick person. The plants in question were “seduced” inter alia by boiling, powdering, crushing and soaking, to increase their rate of reaction and generate more therapeutic power. A total of 37 medicinal plant species belonging to 24 families were reported to be used traditionally in Kavango regions in Namibia, to treat the five different categories of mental disorders. The most reported use of plants was of *Albizia tanganyicensis*, *Ancylanthos rubiginosus*, *Bobgunnia madagascariensis*, *Dialium engleranum*, *Diospyros virgata*, *Elaeodendron transvaalense* and *Guibourtia coleosperma*. Roots and leaves were most frequently used in treatment. Remedies were prepared by boiling, while oral intake and steaming were most commonly used by healers to administer them.

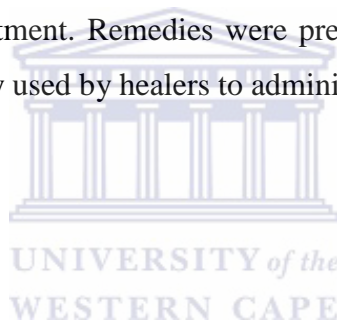
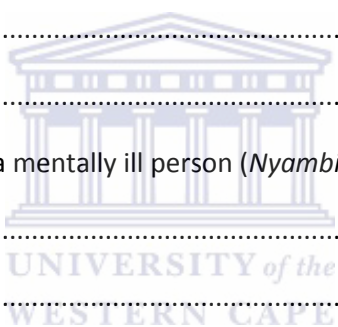


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DECLARATION

I, Michael Shirungu declare that “**The use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.**” is my own work and has not previously been submitted at any university. All the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

Signature.....*mshirungu*.....Date 15 December 2016.....



DEDICATION

In memory of my father Shirungu Tau Marthinus who passed on in 2011- may his soul continue to rest in peace.



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ACRONYMS

CMD	Common Mental Disorders
DSM	Diagnostic and Statistical Manual of Mental Disorders
ICD	International classification of Diseases
WHO	World Health Organization
TK	Traditional Knowledge
IKS	Indigenous knowledge systems
TM	Traditional medicine
UNAM	University of Namibia
UNICEF	United Nation Children's Fund
UWC	University of the Western Cape
NBRI	National Botanical Research Institute
NETHA	Namibia Eagle Traditional Healers Association



CHAPTER ONE:

1 INTRODUCTION

1.1 BACKGROUND/RATIONALE OF THE STUDY

Mental illness contributes greatly to the global burden of disability adjusted life years (DALY) (Kohrt and Mendenhall 2015, p. 14). DALY is a metric used to calculate the impact of health problems on productive activities in society (Kohrt and Mendenhall 2015, p. 37). Health statistic shows that mental illness is one of the largest contributions to DALY - it accounts for 22.5 % of the health burden and is growing rapidly (Murrya et al 2012). It increased with 37.6% from 1990-2010 and is projected to rise further in low and middle income countries (Kohrt and Mendenhall 2015, p. 37). My interest in mental illness topic is informed by the above, but also by my own psychiatric training and as a Registered Nurse with mental health care experience. Thus, when understanding mental illness, I draw on concepts like schizophrenia, anxiety disorder, bipolar disorder or psychosis to make sense of behaviour or to diagnose, treat and when needed refer a mentally ill person. I am also aware that although psychiatry is often represented as hegemonic and increasingly globalized in academic discourse (Watters 2011), in reality it is fragmented, localized or even - where resources are scarce - relatively ineffectual or non-existent. This is especially the case in Kavango, where I have worked as a nurse for many years.

1.2 The main aim of this study was twofold.

First, to explore the social and cultural construction of mental illness from the traditional healers' perspective in Kavango - situated in the northeastern part of Namibia. Hence, my focus for this dissertation is on mental illness as it is understood and treated by traditional healers in Kavango East and West regions. As such, the study examines mental illness within the realm of expertise of *vanganga* (Traditional healers) and explores various local aetiologies and treatment, as well as the social and cultural meaning of these illnesses.

Secondly, I wanted to identify various 'local' mental illnesses and the treatment (including medicinal plants) that is used by the traditional healers in Kavango. In this regard, I specifically focused on the three local categories used by the *vavanga* themselves, namely; (1) *nyambi* (2)

kasenge and (3) *ndjangura*. I furthermore explore the treatment methods used for each category. With regard to medicinal plants I focused on the mode of harvesting, plant part used and the methods of preparation and how they are administered in relation to each particular ‘mental disorder/illness’ as defined, classified and conceptualized by the participating traditional healers.

I draw on culturally informed models elaborated by Dahlberg et al (2010, p. 282) and Post-Structuralist theory concerning accounts of mental illness (e.g. Foucault 1967) to further develop the explanatory frameworks of Kleinman (1980) and advanced by Helman (1994, p. 111), to understand mental illness and treatment offered by the traditional healers as they deal with sick persons. I show that while the three common mentally related illnesses are specific to people in Kavango, and are embedded in their socio-cultural settings (DSMIV, 1994; Littlewood and Lipsedge, 1989), these categories are not fixed or objective, but differ in terms of manifestation and basic underlying assumptions influencing issues of explanation and treatment of the *Vanganga* (traditional healers) who identify them and treat the afflicted.

I was born, raised and have worked in Kavango and over time I observed nursing staff who quietly recommended to families to take a mentally ill relative to a traditional healer. I have on numerous occasions seen ‘mad’ persons in a village, tied to a tree by family members. I have furthermore observed, in the course of my MA research in 2010, the apparently successful treatment of a mentally ill person by a traditional healer through the use of medicinal plants and rituals. Finally, as a medical anthropologist, I draw on an extensive body of research which shows that madness/ mental illness is understood and treated through the lens of culturally informed ideas and conceptualizations which can vary from one societal (and even institutional) setting to another. The ways in which people express and even experience mental illness is also informed and influenced by cultural meanings and the local setting (Ally and Laher 2007, p. 46).

In biomedicine and nursing, health is described as a state of complete physical, mental and social well-being (Pollett 2007, p. 1). This is a quite holistic conceptualization of health. However, there can be huge variations in understandings of mental illness in different socio-

cultural settings and factors that affect mental health can vary considerably from one community to another. I am, however, not trying to argue that such notions are static or only relate to specific groups.

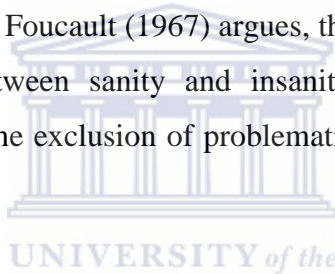
At the same time I am aware that biomedicine (including psychiatry) is a worldwide system and its knowledge, diagnostics, patterns of meaning, treatment and such is prevalent in all countries in the world today (Lock and Nguyen 2010). There is, however, an increased understanding that biomedicine (and psychiatry) is shaped and affected by local contexts and specific historical, political, religious, and/or socioeconomic circumstances (Gibson and Oosthuysen 2009; Wendland 2004). The point I want to illustrate here is that people in Kavango make sense of mental illness in relation to the expertise of either biomedicine (e.g. in the state hospital in Rundu) or of the local *Vanganga*. While my focus is on the *Vanganga's* perspective of mental illness I argue that biomedical practitioners, e.g. psychiatric nurses in Rundu Hospital and the *Vanganga*, often construct mental illness as historically static. In reality both biomedical (psychiatric) and traditional/ local taxonomies of mental illness shift over time. They are not value-neutral and need to be considered in a more critical light (Long and Zietkiewicz 1997; Parker, 1995; Foucault, 1967).



For the purposes of this study, I understand mental illness in the way that Katschnig (2010) does, i.e. as a (psychological) pattern or anomaly, which is potentially reflected in a person's behaviour, and is generally associated with distress or disability by people who see themselves as a community, but which is not considered part of normal development in a person's cultural setting. As such, mental illnesses are defined by a combination of how a person feels or acts, thinks or perceives the condition (Katschnig, 2010), but also how others (the self-described community) understand and make sense of such a person's behaviour. Irrespective of how mental illness is understood, in every societal setting there are people who undoubtedly suffer from it. For them and for their families their 'madness' is not only a construction, but a very real experience of distress and of disruption (Abdullah and Brown 2011).

The difficulty in defining mental illness has been demonstrated by a number of scholars (Becker and Kleinman 2013; Kleinman 2012; Ally and Laher 2007; Long and Zietkiewicz

1997; Russell, 1995; Foucault, 1967). Through these scholars' work it frequently appears that terms such as mental illness, mental disorder and madness are being used interchangeably. In this regard Russell (1995) shows that a major epistemological concern is that the objects of study, namely mental illnesses or mental disorders, are by no means conceptually clear. However, it is useful to identify three contested changing boundaries or oppositions to mental disorder: physical illness, social deviance and mental health. For example, Long and Zietkiewicz (1997, p. 14) used the term "madness" not only to highlight the problematic and shifting meanings of this term (madness), but also to avoid drawing on either biomedical or traditional taxonomies. Although the trajectory of conceptualisation and usage of these ideas revolves around the social phenomena such as suffering and social psychological distress - which influence the "abnormal" in thought, emotion and behaviour - it is also affected by the social, economical, political and health institutions which shape notions of normality and abnormality (Littlewood 2002). As Foucault (1967) argues, the current taxonomies are based on notions of binary opposition between sanity and insanity, oppositions which police the boundaries of society and justify the exclusion of problematic members of society through the compelling logic of scientific truth.



For the purposes of this study I prioritise the term (mental) illness over madness and disorder - given the shifting meanings of both. Disorder, as Good (2012, p. 518) argues, can encompass the historical, political and psychoanalytic. Like madness, disorder can be linked to both the state and individuals, and forces us to give attention to the often violent ways political moral and epistemic 'orders' are established. I am also reluctant to use the term 'abnormal', since what is considered normal and abnormal behaviour varies profoundly across different communities, settings and disciplines. Instead, I explore local notions of mental illness in Kavango by locating it within the broader social context and analysis of social relations.

In Kavango mental illness is locally ascribed to various causes. The first is nature, i.e. physiological, as something that runs in a family, or as a result of injuries, substance abuse etc.

The second cause involves the ancestors and witchcraft.¹ Local people generally refer to mental illness as *kupurumuka* (*Vagciriku and Vasambyu*) *kurundumuka* (*Hambukushu*) and *kuzaruka* (*Rukwangali*).² These words broadly mean chaotic /confused/out of order or lost, to indicate that a particular person is viewed in some or other way as abnormal/ insane or mad. People who are viewed as *kupurumuka/ kurundumuka / kuzaruka* (mentally ill) are often seen as somehow out of control and a danger to themselves and/or others. There is accordingly a perceived need to find ways to treat people afflicted in this way.

When confronted with mental illness local people seem initially to have more confidence in the traditional healers than in psychiatric services. This may be due to necessity since psychiatric services are to all intents non-existent in Kavango. The mentally ill are often heavily sedated and/or sent to Windhoek for psychiatric treatment. As a result the mentally ill are often taken to *Vanganga*, who almost always use rituals and medicinal plants. Due to the rich variety of medicinal plants found in Kavango I investigated the ways in which traditional healers understand and make sense of mental illness, as well as the medicinal plants that they use to treat it, as well as treatment procedures and rituals. An ethno-botanical survey conducted in Kavango³ made it apparent that some traditional healers keep the sick persons at their (healers') place for treatment, including treatment for mental illness. The traditional healers who were interviewed as part of the survey indicated that they have the most success with treating mental illnesses through the use of indigenous medicinal plants and rituals.

My research questions are to some extent informed by the explanatory framework introduced by Kleinman (1980) and further developed by Helman (1994, p. 111). This framework has been incorporated into the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the

¹ Cheikhoussef, A., Shirungu, M., Du Preez, I., and Mumbengegwi, D., (2013) Ethnobotanical Knowledge in Kavango Region; a Field Trip Report. Multidisciplinary Research Centre (MRC), University of Namibia, Windhoek, Namibia.

² Shirungu, M. Cheikhoussef (2013) Discourses of ethno-botanical knowledge on mental illness in Kavango region northeastern part of Namibia; unpublished paper presented at the 4th International conference of Science and Indigenous knowledge systems, University of the Western Cape, South Africa.

³ Cheikhoussef, A., Shirungu, M., Du Preez, I., and Mumbengegwi, D., 2013. Ethnobotanical Knowledge in Kavango Region; a Field Trip Report. Multidisciplinary Research Centre (MRC), University of Namibia, Windhoek, Namibia.

Explanatory Model Interview Catalogue (EMIC), Short Explanatory Interview Model (SEMI) and the Illness Perception Questionnaire (IPQ). According to White (2002) and Weiss et al (1992) these frameworks can vary from the biomedical/psychiatric - informed by particular 'Western' histories and ideas - to e.g. Chinese and Hispanic 'models' that view illness as an imbalance of forces. Other frameworks understand mental illness as being influenced by unseen forces such as the ancestors, spirits, demons, curses and witchcraft etc. Such frameworks are often hybridized. For example people may believe that HIV is transmitted through sexual intercourse and/or contaminated blood, but simultaneously think that it is caused by witchcraft.

Although there have been critiques of explanatory frameworks, especially the ones that tend to understand 'culture' as somewhat static (Lynch and Medin 2006; Scheper-Hughes 1990), I still found them useful as guidelines to the kinds of questions to ask and explore in my own study. I did, however have to make a shift in the kinds of questions I asked, because I was not looking at the understandings and experiences of the sick themselves - as is usual when using the explanatory model framework. Instead I explored the ways in which traditional healers themselves understood or made sense of and treated mental illness.

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For the purposes of this study, I wanted to ascertain how traditional healers in Kavango understand mental illness. To do so, I posed the following questions:

1. When does a traditional healer perceive a person as mentally ill?
2. What is mental illness called/ how is it named?
3. How does a traditional healer 'diagnose' mental illness (in general and in the case of specific conditions)?
4. Is it perceived as an illness?⁴
5. How is the mental illness treated? What is used, who is involved etc?

1.1 ⁴ Illnesses are broadly understood as the syndromes from which members of a particular group claim to suffer. Their socio-cultural setting and ideas usually provide an aetiology, a diagnosis, preventative measure and regimes of healing (Helman 1994, p. 108). Contrastingly, disease as is a condition assigned/diagnosed by a health practitioner like a nurse or a doctor. It draws on a biomedical framework. Thus a disease is something, e.g. an organ has. I will discuss this further in chapter five under 5.2 on traditional healers' conceptualization of *uvera* (illness).

1.3 Contextualizing mental health services in Namibia

After independence the Namibian government tried to extend mental health services, but the country remains short of mental health facilities and skilled mental health practitioners. At the moment there are only two psychiatric hospitals in the country: Windhoek Mental Health Care Centre and Oshakati Psychiatric Unit. The former has a bed capacity of 112 and provides outpatient and inpatient services. The centre also houses the Forensic Service Unit with 99 beds with a range of professionals namely; two psychiatrists, three general practitioners, two clinical psychologists, 36 psychiatric registered nurses, three registered nurses, 45 enrolled nurses, four occupational therapists, and two social workers (Kapitako 2016, p. 10). While Oshakati psychiatric unit has 80 beds, the unit often admits up to 100 patients with one psychiatrist, one general practitioner, seven psychiatric registered nurses, seven registered nurses, 18 enrolled nurses, one occupational therapist and one social worker (Kapitako 2016, p. 10). All district hospitals have emergency mental health services as part of outpatient services but have no specialised staff. A limited range of psychotropic medications are available. In this regard, The Ministry of Health and Social Services has only four full-time consultant psychiatrists in the country. The private sector has five psychiatrists practising in Namibia (Uukongo 2014, p. 12). Namibian universities do not offer any specialised courses in psychiatry but mental health forms part of the Medical and Nursing curricula at the University of Namibia. Mental health services are almost non-existent in Kavango *per se* (Kangootui 2012). People with mental illness are most frequently heavily medicated with antipsychotic drugs available in the local dispensary and/or sent to the psychiatric hospital in Windhoek for in-patient treatment (Feinstein 2002, p. 311). After discharge, and once back in Kavango, they receive almost no ongoing care until they relapse again (Ibid, p. 311). Under these circumstances, the mentally ill in Kavango are sometimes, as indicated above, chained up or otherwise restrained by their family. Most frequently they are taken to traditional healers for treatment.

The latter often use plant medicines, rituals and such for this purpose (Shirungu, Cheikhyoussef 2013. p. 15). In Namibia there is some move towards complementarity and collaboration between healing systems biomedical and ‘traditional’ (Harrison et al 2002, p.1), especially in

relation to primary health care, but the process has been very slow⁵. In some countries, like South Africa, scholars have similarly called for the inclusion of traditional healing systems in mental health care in particular (Long and Zietkiewicz 1997; Swartz, 1996).

Such dialogue is nevertheless absent in both academia and public discourse in Namibia. In spite of various health reforms which have been implemented in the country since independence in 1990, the inclusion of traditional healing into mental health care has not been prioritized. In this regard, the 2005 National Policy on Mental Health is notably silent on the issue of traditional healing (Marcus, 2014) although people draw on both biomedical and traditional taxonomies and treatments in order to address their mental illness. The inclusion of traditional healing into Western (i.e. psychiatric) frameworks of treatment can arguably be beneficial in a country with few resources in this regard. This trend is supported by the World Health Organization's (WHO, 2005) estimate that more than 80 % of Africans visit traditional healers. Davids et al (2016, p. 756) warned that although in literature it is often reported that about 80% of African people make use of "traditional" medicines, in reality frequency of use fluctuates from one area to another and between rural and urban areas. Nonetheless, the authors pointed out that due to increased cost, side effects and unavailability of pharmaceuticals, especially in rural areas people often turn to traditional medicine to manage their health and as such academic researchers, as well as the pharmaceutical industry, consider THM as a potential source of new, safe and affordable alternatives medicine (Davids et al 2016, p. 756).

Thus, traditional healers who make use of traditional medicine are a vital link to supplying the needed services in their communities as populations grow, and health concerns continue to increase in complexity and case numbers (Harrison et al 2002, p. 1). Swartz (1996) also notes that there is little evidence to support the efficacy of traditional healing and that many have failed to consider the political and critical aspects of dialogue between the two paradigms. There is, however, a need to understand, make sense of and, if possible, appraise 'traditional' healing systems and treatment, specifically 'traditional' herbal or plant remedies to support existing conventional therapies. It is the scarcity of in-depth, applied research, as well as the great need for medicines in Namibia, that is the impetus for this thesis.

⁵ See chapter four for further discussions.

The study is furthermore situated against the background of the World Health Organization's 2005 statement of, "No health without mental health" (WHO 2005). Yet, all over the world, there are vast gaps in resources and trained staff. The above endorsement highlights the intrinsic and indispensable role of mental health care in biomedicine, as well as complementary health care services e.g. 'traditional' healing in all countries (WHO 2005).

Nonetheless, in Namibia the lack of access to mental health services of good quality is profound, especially since resources are limited and mental health services are often sidelined (Coomer 2013, p. 40).

Becker and Kleinman (2013) show that the global prevalence of mental illness is substantial: it constitutes an estimated 7.4% of the world's measurable burden of disease. In the case of Namibia, there are currently no reliable statistics available concerning the prevalence of mental illness (Uukongo 2014, p. 21). However, according to statistics from the Ministry of Health and Social Services, it is estimated that about 9 257 people were treated for mental illnesses at various health facilities countrywide in 2015, compared to 8 527 people the previous year. In the absence of accurate data it is assumed that the general state of mental health globally is fairly representative for Namibia as well. Thus about 7-8% of the population is estimated to suffer from mental illness (Republic of Namibia 2000, p. 4). Namibia also has a history of colonialism. In this regard Czyzewski (2011) argues that colonialism and colonial policies had long-term effects on the physical and mental health of local people, as well as in gaps in the provision of e.g. mental health care for the people of Namibia.

1.4 Thesis outline and brief description of chapters

The thesis consists of seven chapters which mainly focus on mental illness, traditional healing and the use of medicinal plants in Kavango. The following is the description of each chapter.

In **Chapter 2** seminal work on mental illness is discussed. Literature in medical anthropology and psychiatry in relation to the social, cultural, political and historical contexts of mental illness and the development of ideas and theories about them is reviewed. The chapter also discusses the notion of culture-bound syndromes and analytical frameworks used in this study. I

examine anthropological questions, methodologies and theories around mental illness. Finally I give an overview of work done in Namibia that relates to my research topic.

Chapter 3 deals with methodological strategies that were used in the study. It sets the scene by discussing the area of research with a brief historical background of its people, language, social economic status and clan affiliation among other. In particular the chapter discusses key methodological research methods used, challenges faced in the field, and how I positioned myself and negotiated my status as a local researcher and trainee healer. It engages with debates concerning doing anthropology ‘at home’ with regard to its methodological challenges, strengths and weaknesses (Forster (2015, p.14). The chapter also speaks to the idea of positionality, i.e. the constant shifting social relations of being a local (native scholar) and a researcher (academic) in search for data from traditional healers (*Vanganga*).

Chapter 4 investigates various categories of healers in Kavango, their way of entry into the profession, diagnostic process and their legal status. In particular the chapter looks at the notion of *Nganga* (*singular*) *Vanganga* (*plural*) (traditional healers) in Kavango and argues that the *nganga/vanganga* should be understood around the three concepts, namely *Kangangwena* (assistant traditional healer), *Nganga* (general traditional healer) and *Nkurunganga* (expert traditional healer). The chapter argues that traditional healers form part of the local health care system which historically has been unregulated and free of legislative interference.

Chapter 5 discusses the social and cultural construction of mental illness from the traditional healer’s perspective in Kavango. This chapter deliberates local notions of mental illness by looking at the different categories in Kavango and systematically describing its perceived pathophysiology to draw out the social meaning of the illness.

Chapter 6 focuses on various treatment methods that the traditional healers in Kavango use to treat patients that are suffering from mental illness. The chapter further elaborates preparation methods and the parts of the plant used in the treatment.

Chapter 7 is the Conclusion. In it I discuss the main ideas that were raised in the thesis and offer some suggestions for future research on mental health and IKS in Kavango in particular and Namibia in general.



CHAPTER TWO

2 LITERATURE REVIEW

2.1 INTRODUCTION

This chapter will discuss seminal work on mental illness in medical anthropology and psychiatry in relation to the influence of social, cultural, political and historical contexts on it. There is a growing body of literature in medical anthropology (Washington et al 2016; Kohrt and Mendenhall 2015; Patel et al 2012; Dahlberg 2010; Brown and Barret 2010; Lock and Nguyen 2010; Inhorn 2010; Kleinman 2009; Lee et al 2006; Good et al 2007; Farmer 2003) as well as its interface with ethno-medicine, medical ecology, epidemiology and psychiatry (Becker and Kleinman 2013; Lock & Nguyen 2010) that I will explore in this chapter. This body of work examines key methodological issues as well as successes and failures concerning mental illness in global health through an anthropological lens based on historical, economical, political and socio-cultural contexts.

I focus on biomedicine to some extent because it has gained momentum and started objectifying the body by means of technologies, in a systematic approach in clinical settings, describing and classifying symptoms as part of disease taxonomies from the beginning of the 18th century (Lock and Nguyen 2010, p. 128). Biomedicine, which includes the specialization of psychiatry, represents state health care systems in all countries in Sub-Saharan Africa today. I therefore examine mental illness by looking at earlier academic analysis to ascertain how different scholars have theorised mental illness as a subject of enquiry – especially as a biomedical one – in relation to treatment and diagnosis. I also explore challenges in identifying and treating mental illness in different cultural settings: which also depends on the availability of health care linked to the social, economic and political issues (Kohrt and Mendenhall 2015, p. 20).

The notion of culture-bound syndromes and analytical frameworks of illness is discussed, because local notions of mental illness in different communities have a strong influence on the emergence of how mental illness symptoms, causes and treatment are expressed as unique

health problems of biomedicine. In particular anthropological questions, methodologies, and theories around mental illness are scrutinized, ending with an overview of work in Namibia that relates to my research topic. Anthropological contributions can help in optimising the acceptability and implementation of mental health policy which are contextual in the social and cultural setting of the people especially in low resource communities like Kavango.

2.2 A brief history of psychiatry

In an overview of the history of psychiatry Shorter (2007, p. 20) points to an increased emphasis on topics such as psychopharmacology, electroconvulsive therapy, and the interplay between psychiatry and society. My focus as an anthropologist is on the latter, given that psychiatry is a broad field and academic interests in it will vary depending on the discipline one is in. However, the history of psychiatry, viewed through the lens of any given discipline is not that old since mental health care was mainly provided by family members before the 20th century (Kohrt and Mendenhall 2015, p. 37; Shorter 2007, p. 20). The medicalization of persons with mental illness emerged in the 19th century prior to which mentally ill persons were often chained, isolated and put in asylums. Lock and Nguyen (2010, p. 188) noted that the medicalization of madness was not evident in most parts of the world until after the colonial era when psychiatry became a global hub for the people who were considered to be mad.

According to Adam (2014, p. 509) psychiatry – which draws almost exclusively on biomedical knowledge - nonetheless has yet to provide reliable biomarkers to aid diagnosis and treatment of mental disorders. Up to till now self-reported symptoms and their subjective interpretations remain the basis for clinical diagnosis. While biomedicine draws on psychiatric categories to understand, diagnose and treat suffering which affects emotions, behavior, cognition, and social relations, these criteria have not been stable over time. Psychiatric diagnoses have changed considerably over the history of its most important diagnostic ‘tool’, the Diagnostic and statistical Manual of Mental Disorder the (DSM)⁶. Medical anthropologists have produced

⁶ DSM is the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association (APA), offers a common language and standard criteria for the classification of mental disorders (Blashfield, K (2014, p. 25). It is used, or relied upon, by clinicians, researchers, and policy makers together with alternatives such as the international statistical classification of Diseases International Statistical Classification of

critical analyses of the changing DSM as evident of the cultural construction of definitions of normality and abnormality by questioning the cross-cultural universality of biomedical categories (Kohrt and Mendenhall 2015, p. 37; Scheid 2012, p. 2; Dahlberg et al 2010, p. 282; Kleinman 1998). As such, diagnosis needs to take cultural aspects of symptoms and presentation into account to prevent over- or under diagnosis of mental illness. Getting the correct diagnosis is vital since it informs treatment. The latter is also more complex than simply the delivery of medication: because mental illness stems not only from biology but can also develop out of social conditions and experiences (Kohrt and Mendenhall 2015, p. 37). Thus, treatment requires a culturally adapted psychological and delivery of health care that will not worsen mental health problems, e.g. through stigmatization or an increased economic burden on the health care system (Ibid).

Colonial era psychiatry struggled with an array of pathologies that did not correspond to Western training on diagnosis and treatment, and there was no universal biological template for addressing mental illness, thus psychiatrists in colonial settings experimented with prevailing ‘Western’ models of the psyche to understand and treat madness (Lock and Nguyen 2010, p. 189). Histories of colonial psychiatry have stressed the coercive and often cruel treatment reserved for those suffering from mental illness in asylums. The idea of the mental asylum spread in the 19th century via colonialism as Britain, the Netherlands and France passed lunacy laws and implemented asylum practices. This involved seclusion and isolation of mentally ill persons: here they frequently led inactive lives despite an absence of legitimate medical reasons for them to do so (Kohrt and Mendenhall 2015, p. 10). Foucault (1967) refers to this as the “great confinement”. Asylums were places where people, who were considered ‘mad’ by society, were confined by those who had the power to do so, not the medical establishment. According to Foucault (1967) a shift happened in the nineteenth century when psychiatry came to establish mental disorder as a distinctive field of study. In this regard, biomedicine presented and viewed mental disorder as a distinctive type of illness to be understood, as with other types of illness, in physiological terms, to be treated through physical intervention (Long and

Diseases (ICD), produced by the world health organization (WHO). The DSM is now in its fifth edition, DSM-5 published on May 18, 2013 which evaluate patient on five axes or dimensions rather than just one broad aspect of 'mental disorder as it was the case with previous DSMs (Blashfield, K (2014, p. 25)

Zietkiewicz 1997, p. 16). Frantz Fanon, a psychiatrist deployed in an asylum in Algeria in service of the French colonial administration, exposed barbaric conditions, racism and colonial exploitation which affected the institutions in which psychiatric inmates were held (Lock and Nguyen 2010, p. 189). In this regard, Fanon initiated and experimented with a form of “social therapy ” by integrating patients into a semblance of normal life based on psychoanalytic and existential theories prevalent at the time, in order to refute racist ideas that colonial subjects were somehow different or childlike versions of more fully realized Europeans (Lock and Nguyen 2010, p. 189).

Although asylums became relics of the past with the introduction of psychiatric institutions, in some third world countries like Namibia - particularly rural areas where I did my fieldwork - the practice of chaining mentally ill persons is still common. This does not, however happen in mental health facilities *per se*, but rather in local communities- although such practices are illegal in terms of the country’s Constitution.

The major turning point in psychiatry came with the German scholar Emil Kraepelin, who founded the current psychiatric nosology referred to above, the DSM, during the 20th century in an attempt to classify madness (Bentall 2005, p. 221). Kraepelin introduced a number of diagnostic concepts like ‘schizophrenia’, bipolar disorder, and ‘manic depression’ that are still widely used today. He argued that there is a clear dividing line between madness and normal functioning. Kraepelin’s developed the DSM which was widely adopted in Psychiatry during the 1980s. The Manual mainly dealt with the classification system based on aetiology and psychological processes, with checklists of observable symptoms (Good 1992). The nosological organization, labels, symptoms lists, and criteria for psychiatric diagnoses have changed considerable over the history of DSM. Dahlberg (2010, p. 282) explains that this nosology sought to provide a universally valid description of psychiatric disorders based on a positivist assumption that diagnostic categories are direct descriptions of observed empirical realities (see also Spitzer 1994). The theoretical phenomenological classification of mental disorders was adopted as *The Diagnostic and Statistical Manual of Mental Disorders* (DSM - III) (American Psychiatric Association, 1980).

The second major development came with increased production of psycho-pharmaceuticals for mental illness, which provided a kind of global standard furnished by biology for non-psychiatric illness (Lock and Nguyen 2010, p. 189). This was enhanced with the discovery of chlorpromazine (Thorazine, Largactil) in 1952 to treat schizophrenia- “a kind of psychic penicillin” that opened the therapeutics of psychosis (Shorter 2007 p. 22). In this regard, the biomedical framework assumes that disease processes operate in the natural sphere, unaffected by cultural influences. Culture is seen as static, bounded and as merely an interpretive and descriptive layer that obstructs understanding of the underlying physical reality (2010, p. 283).

A number of scholars (Long and Zietkiewicz 1997; Parker, 1995; Chesler, 1974; Foucault, 1967) have questioned the biomedical approach and argued that mental illness cannot be universal because different cultural settings frequently give rise to different manifestations with a distinct symptomatology which is endemic to a particular culturally influenced environment. Therefore, mental illness comprises culturally specific "culture-bound syndromes" (DSMIV, 1994; Littlewood & Lipsedge, 1989). My point is that, historically, scholars who studied mental illness in biomedicine and the social sciences faced the conceptual problem of defining mental illness, given that categories of mental illness are not fixed or objective but rather participate in productive and exclusionary practices in the exercise of power (Long and Zietkiewicz 1997, p. 2).

In Namibia mental illness is often understood to be the realm of expertise of either the biomedical psychiatrist or traditional healers. It is argued that these traditions both may conceptualise mental illness as historically static and amenable to non-contradictory categorization, while in reality mental illness is constructed in different ways and offers different positional narratives (Long and Zietkiewicz 1997, p. 2). As such Foucault (1967) argued that conceptualisations of mental illness set up power relations between "sane" and "insane" -thus allowing for the justification of certain practices which can lead to inclusion and exclusion, or offer constructions of "truth" and "expertise", all of which may be incorporated into subjectivity and lived experience, in support of certain institutions. There is a great deal of common interest between psychiatry and anthropology – which I will explore further in the next section.

2.3 Anthropology and psychiatry

According to Scull and Golson (2014) the formation and transformation of local treatments of madness are major areas of study in social and cultural anthropology, since madness is a major disorder of social ties and a universal problem for all societies. The authors argue that “treatment” should be understood on three different levels. Firstly, as treatment of the problem that madness poses to social order; secondly, as treatment of an ailment on the basis of a therapeutic system that has the option of calling on specialist knowledge (e.g. a classification, an etiology, a pharmacopoeia, etc.) in order to identify the disorder or determine its nature, followed by providing an appropriate intervention. At the third level it can be understood as moral treatment of people experiencing madness and of trying to find a solution to their state of disorder (Scull and Golson, 2014.)

For my study I focus on the first two aspects mentioned and relate it to my study area. The seminal work of Kleinman (1980, 2012), Young (1980), Littlewood (1986), Helman, (1994) Good (1994) and others show that, since its inception, anthropological writing on ‘traditional’ medicine has been linked to criticism of biomedical theories and medicine as practiced in society. However, Good (1994) explains that the first, explicitly applied, work of medical anthropologists involved in international public health in the 1950s, was formulated not only to enhance the effort of public health practitioners but as a critique of their cultural naiveté.

But before that the work of two physician anthropologists Charles Seligman and Rivers in 1898 contributed and influenced mental health (Kohrt and Mendenhall 2015, p. 37). For example Rivers’ work influenced mental health care when lessons he learnt from observing healing in the Torres Strait were applied to British soldiers who were receiving medical and psychiatric treatment during World War I (Kleinman 2012; 2006). Rivers studied various concepts ranging from kinships, to perception of colour, to mode of healing while Seligman was interested in the signs of mental illness among the Torres Islanders: he concluded that it was largely absent - therefore it did not exist (Kohrt and Mendenhall 2015, p. 37). Seligman’s conclusion is now known as the “Seligman error” that is, the assumption that an illness category does not exist in a

certain community if symptoms known elsewhere are not observable.

Doing research on mental illness can be challenging when trying to define and/or classify mental illness in any given context. Foucault (1967) highlighted this in *Madness and Civilization* in which he explored the shifting relationship between ‘unreason’ and ‘madness’. Ultimately, Foucault argues, ‘madness’ became mental illness, which became the domain of psychiatry, is under psychiatric control and can be treated medically. Foucault further stressed that madness is neither ‘natural’ nor stable. Instead it shifts depending on the societal setting in which it exists. Certain intellectual, economic and cultural structures affect how madness is understood or known in a society and also how it is experienced. Thus, in a sense, society constructs its experience of madness. Ultimately, Foucault viewed madness as located in particular cultural spaces in society. The ways in which such spaces are shaped, as well as the effects it has on those who are viewed as mad, is dependent inter alia on societal ideas and discourses in a specific time.

Foucault’s *History of Madness* (2006), similarly showed that the notion of what being mad is, has shifted and been transformed over time, e.g. from the middle ages to the age of enlightenment. In each period of history the ways in which madness is constructed can also give insight into the value systems of that particular historical time. By constructing certain people or behaviour as mad, society can understand itself as sane.

Foucault explored the processes through which ‘mental illness’ was brought into existence and became the object of psychiatry. He shows that early writers, especially those that have been exposed to social science studies, indicated that mental illness is not like any other medical conditions which are presented by biomedicine as universal, but rather varies enormously. As Oloyede (2002, p. 252) explains, the history of psychiatry, as well as the anthropological critique of it, seems to constantly shift in presenting the confines of psychiatric conditions. He shows, for example, that in medieval Europe the cultural schemas of that time structured mental illness around concepts of demonic possession and witchcraft. During that period life was seen as a constant struggle between the forces of God and Satan. In this world view the mentally ill were culturally schematised as either demonically possessed or the victims of witchcraft.

Oloyede (2002, p. 252) argues that as time passed, there was a shift from this conception of mental illness to a disease-centered view, which assumes a strong relationship between the rise of science and the ‘true’ biological nature of mental illness. Science, in effect, yielded a generalized knowledge concerning fundamental determining conditions for the occurrence of various types of illnesses that resort under mental illness and methods for their treatment.

Nonetheless, this new paradigm shift in mental illness to a disease centered view did not give biomedicine the ultimate power on mental illness. There are some critical clinical analyses of psychiatry arising from the general development in anthropology and the humanities. In this regard Scheid (2012, p. 1) pointed out that the classification systems that define psychiatric disorders, namely the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM), are based on self-descriptions of mental states elicited from patients living in advanced capitalist societies, and these draw on historically specific definitions of disease, evidence and facts.

Scheid (2012, p. 2) argues that the above classification systems thus constitute “western cultural documents par excellence” which is far from objectively assessing mental illness. Psychiatry arguably also seeks to shape specific ways of citizenship and of being a person that, rather conveniently, match the western neoliberal economic order. By taking this approach, biomedicine (and psychiatry as its extension) displaces modes of dealing with mental health issues that emphasize interpersonal relationships or social and economic causes of mental distress. Dahlberg et al (2010, p. 282) noted that Psychiatry increasingly adopted the biomedical model during the 1970s, while transitioning from a classification system based on aetiology and psychological process, to one based on checklists of observable symptoms.

The psychiatric nosology sought to provide a universally valid description of psychiatric disorders based on a positivist assumption that diagnostic categories are direct descriptions of observed empirical realities. Therefore, the biomedical framework works on the assumption that mental illness or madness or psychiatric problems are a disease. Its processes are accordingly understood to function in the natural sphere or on the level of the physiological. Psychiatric conditions or disorders are thus seen as largely unaffected by cultural influences: ‘culture’ is

thus merely an interpretive and descriptive layer that hinders understanding of the underlying physical reality (Comelles and van Dongen 2002). It is this trajectory that anthropologists profoundly criticize. Anthropology accordingly questions this nosology, arguing that it

- i. Determines a priori the relevant signs and symptoms defining disease;
- ii. Focuses on the individual and the biological to the exclusion of psychosocial and interpersonal context
- iii. Medicalizes social problems
- iv. Omits culturally informed meanings of terms, ignoring the role of social construction in the development of medical (and by extension local) concepts
- v. Falls into the category fallacy of assuming that Western psychiatric categories are universal whereas local categories are culture bound and
- vi. Uses a narrow set of criteria for diagnosis that improves reliability at the expense of validity (Dahlberg et al 2010, p. 282).

Although symptom-based psychiatric nosological systems, exemplified in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), have increased reliability of diagnosis and provided insight into distinctive:

...phenomenology, social origins, prognosis, and psychobiology, the psychiatric approach has not accounted for the role of cultural understandings and meanings in relation to phenomenology, social origins, prognosis, and biology of psychiatric or mental health conditions (Dahlberg et al 2010, p. 282).

It must be noted that even though DSM and ICD are western-centric, the understanding and treatment of mental health issues around the world and health care in the West itself is slipping away from the control of biomedicine and is now, de facto, pluralistic. The latter is due to the increasing importance of Asian economies and philosophies globally, as well as e.g. greater sensitivity to the local meanings and usages of health care options all over the world. Asian medicines, in particular, are amongst the most influential of the many so-called complementary and alternative medicines (CAM) that now compete with biomedicine in the global health care market (Scheid 2012, p. 3). An emerging complementary medicine is African ‘traditional’ medicine which is vital, but currently lacks in-depth studies.

2.4 Culture-bound syndromes and Idioms of distress

There are some mental illness conditions that are recognized as unique and specific to particular cultural settings and which relate to particular kinds of historical circumstances. These are generally referred to as culture-bound syndromes and they denote recurrent, locality-specific patterns of aberrant behavior and troubling experience which are not usually linked to a particular DSM-IV diagnostic category (Guarnaccia and Rogler 1999). Such conditions have limited distribution and are recognized and experienced in particular settings, in fairly specific ways. For example, in South Africa *Amafufunyana* (a kind of spirit possession) is such a culture bound syndrome, often described as violent, uncontrollable behaviour understood to be caused by spirit possession. It frequently manifests in the sufferer speaking in languages not their own (Niehaus et al 2004). In Nigeria, for example, *Ogun oru* (nocturnal warfare) is also seen as such a syndrome. People who suffer from it are typically “attacked” at night while asleep, and when they awaken they are unable to sleep again and the sufferer becomes agitated, behaves in unexpected ways and may bleat like a goat (Morakinyo, 2010). Long and Zietkiewicz (1997) noted that culture bound syndromes are often presented as static illness which does not change. However, Lund and Swartz (1998) argued that e.g. conceptualizations of *amafufunyana* are in themselves not static but have been differently described by sufferers and in literature.

A stronger form of cultural specificity would suggest that madness differs culturally not only in terms of manifestation, but also at the level of basic underlying assumptions that influence issues of explanation and treatment. This is often articulated in terms of western versus traditional differences, in which western conceptualizations are understood as ostracizing whereas traditional systems include the mad person within the system. While it will be suggested later that this version may be simplified, there does seem to be indication that madness is not universal at either symptomatic or explanatory levels (Parker, 1995).

In medicine and medical anthropology a culture-bound syndrome or culture-specific syndrome is understood as a combination of psychiatric/mental/experiential and somatic symptoms that are considered to be a recognizable condition only within a specific societal or cultural setting.

It can also be understood as particular idiomatic and somatic expressions of distress (Reis 2013). For example, in Northern Uganda children are often ‘diagnosed’ by traditional healers as suffering from ‘haunting spirits’. Reis (Ibid) argue that these can be interpreted as manifestations of social crises and trauma. Such a ‘syndrome’ also allow children to articulate and communicate their precarious positions within families and communities under duress. Because culture bound syndromes or idioms of distress, as Reis (2013) refers to it, are so localized, it is recognized and people tend to express it in particular ways (Rebhun 2004). Such syndromes show no apparent biochemical or structural alterations of organs, body or functions, and the condition is not recognized as such in other cultural settings.

It must be noted that the term culture-bound syndrome was included in the fourth version of the Diagnostic and Statistical Manual of Mental Disorder (American Psychiatric Association, 1994). Many of these patterns are locally considered to be "illnesses" or at least afflictions and often, as seen above, have local names. They are localized, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations (Rebhun 2004). In the case of mental illness there are unique forms that such illnesses take. An example is *windigo* among the Northern Algonkian language group of native Canadians. Launer (2003) shows that *windigo* usually develops in winter when families are isolated by heavy snow for months in their cabins and have inadequate food supplies. The initial symptoms of this form of mental illness are usually poor appetite, nausea, and vomiting. Subsequently, the individual would develop a characteristic notion of being transformed into a *windigo* monster: a supernatural being that eats human flesh. Hence, those affected by it increasingly see others around them as being edible.

Such culturally specific expressions of suffering or distress (Sargent 2003) are understood as ways to express and communicate the affliction in a manner that makes sense locally and which enables local people to act on it in some or other way (de Jong & Reis 2010). I include the section on culture-bound syndromes because traditional healers most often treat people who suffer from the above kinds of mental illness. In Kavango three major local illnesses are associated with mental disorders, namely *kasenge*, *ndjangura* and *nyambi* (as discussed in chapter 5).

2.5 Analytical frameworks, Cultural Models and Embodied Experience

I understand ‘culture’ as dynamic, and will initially draw on the notion of explanatory frameworks to scrutinise mental illness and treatment offered by the traditional healers. I find this framework useful because it helps me to understand how traditional healers in Kavango conceptualize mental illness as they deal with patients on daily basis. For example, bodily experience shapes cultural models of emotions, such as in the U.S. metaphor of anger-as-heat. This is somatically expressed in a rise in skin temperature, often accompanying the emotion. ‘Cultural models/frameworks’ are formed out of various social and physical experiences, and as indicated above, they play a role in shaping those experiences (Dahlberg et al 2010, 282).

Therefore, I hope by loosely applying and interrogating the notion of such frameworks, to gain and enhance anthropological insight into mental illness, with a discussion of how mental illness can or cannot be integrated into theories of cultural models/ frameworks. I hope to offer a basis for new approaches that transcend the limitations of constructivist paradigms because such approaches ignore certain aspects of the process and experience of mental illness and distress. These are issues that I will include in my study to fundamentally question a large body of anthropological work that has tended to view mental illness as cultural constructions while viewing physical diseases as universal processes ‘coated’ in cultural interpretation (Good 1992, p. 187). Not only is a purely constructivist account “increasingly naïve in the study of psychopathology” (Good 1992, p. 187) it also ignores the fact that physiological as well as social processes are increasingly understood as being deeply cultural, since they are involved in health and illness (Lock and Nguyen 2010).

2.6 ‘Traditional’ knowledge systems, mental illness and plants

Mental health and -illness is influenced by many interconnecting factors (Czyzewski (2011) such as social, cultural and social economic status among others. Disparities are also produced and reproduced by aforementioned circumstances. As indicated, above, mental illness, as well as mental health can even be differently conceptualized by health care providers, the ill and

their care-givers. There may be specific vocabularies to describe afflictions of the mind (or even the spirit) that may be comparable to biomedical mental ill-health categories, or not (ibid). The understanding that some people are mentally ill and in need of treatment is, however, commonly accepted in Namibia. Nonetheless, despite the World Health Organisation (WHO, 2001) promotes of the incorporation of Traditional Knowledge (TK) (including traditional medicine, traditional healers) into the formal health care system in Namibia it has been very slow (Gibson and Oosthuysen 2009, p. 9).⁷ TK is defined by the WHO as:

Knowledge, skills and practices based on the theories, beliefs, and experience indigenous to different cultures, whether explicable or not, (which are) used in the maintenance of health and wellbeing whether physical, spiritual and/or mental.

Such ‘traditional’ knowledge (TK) should ideally be incorporated into a system of primary health care. In Namibia, according to the draft (2004) Access to Generic Resources and Related Traditional Knowledge Bill, TK includes biogenetic resources and is defined as being ‘accumulated’ and developed over years in local communities. It includes ‘traditional’ medicines, technologies, land use practices and philosophical knowledge (Gibson and Oosthuysen 2009: p. 9). It must be noted that the categories IK (South Africa) and TK (Namibia) are currently at the centre of much research and debate and raise the problem of ‘translating’ or ‘interpreting’ knowledge across different contexts and between diverse modalities (Shirungu 2010).

As is presumably the case with most pluralistic health care settings, the diverse knowledge conventions or ‘traditions’ involved in sickness and the search for health, while imbued with relations of power, are also translated into new settings and, sometimes, hybridized (Gibson and Oosthuysen 2009). TK (as understood in Namibia’s draft policy above) is passed on through teaching, example, practice and apprenticeship. People who use medicinal plants, e.g. traditional healers, assess their therapies through outcomes, discussion and observation. ‘Traditional’ ways of knowing and understanding the efficacy of plant medicines are nevertheless not bounded or static.

⁷ See chapter four for further discussions in this regard.

Mental health care providers are a resource to help people to deal with the stresses and challenges of everyday life. Hence, good mental health care contributes to the quality of individual, communal and societal lives. In this regard, traditional healers in Kavango play an important role. They are broadly referred to as *nganga*. Mbambo (2002, p. 180) defines a *nganga* as a person who becomes a member of the group of people believed to be knowledgeable in healing all kinds of sickness and diseases.⁸

A number of studies have looked at traditional healers and their treatment of mental illness (Sorsdahl et al 2009, 2013; Gureje Oye 2010). In research conducted in South Africa it was found that mentally ill patients were treated by both psychiatric health care staff and traditional healers (Sorsdahl et al 2009). According to Sorsdahl et al (2013) approximately half (41-61%) of the patients who attended a state health facility in relation to mental illness, also consulted traditional healers. The consultation of traditional healers by the mentally ill, and the use of medicinal plants to treat them, is common in sub-Saharan Africa. These are sometimes the only available resources for patients and their families (Gureje Oye 2010). However, there is also a great deal of debate, especially within the formal health care system, concerning traditional healing and the possibility of collaboration with biomedicine (Wreford 2008). There are also contestations, as seen above, over the conceptual basis of science and medicine, and traditional healing. In relation to the former it is often argued that biomedicine represents a particular, western- or eurocentric way of looking at the world, which is not necessarily privileged locally as I have discussed above.

Traditional medicine by contrast, it is then argued, draws on relativistic or ‘emic’ perspectives in cross-cultural settings and is culturally sensitive. However, Long and Zietkiewicz (1997, p. 24) caution that while it is more accepted that biomedical taxonomies ignore cultural specificity and historicity, it could be argued that so too do “traditional” taxonomies. For example “traditional” discourses may imply that there is one ‘culture’ that is shared by all those who, e.g. share particular ancestors, but this is unable to account for the varied experiences of people. Further, traditional discourse may call upon a notion of timeless wisdom passed down in

⁸ I will discuss traditional healers in Kavango in more details in chapter four.

untainted form from many generations ago. To think that traditional taxonomies have not been influenced by the profound social changes of the last century seems to be naive and dismissive of the influence of current social configurations on the presentation, understanding and treatment of madness (Long and Zietkiewicz 1997, p.24). Therefore, the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) argue that both biomedicine and its medications, as well as 'traditional' healers and their treatments can have therapeutic efficacy, hence the need for collaboration (Sorsdahl, et al,2013: Gureje Oye 2010). There is nonetheless an urgent need to understand and document traditional healing as well as its treatments, and this process is quite advanced in South Africa (Thornton 2009; Wreford 2008).

There are few in-depth studies on traditional healers and the use of medicinal plants to treat mental illness in Kavango. In relation to the latter Shirungu (2010, 16) argues that early studies like those of Bosch (1964), Van Tonder (1966) and Mbambo (2002) provide some basic background about traditional healers in Kavango, but nothing about mental illness and/or its treatment. However, a number of ethno-botanical studies have included research on the use of medicinal plants. Such studies include those of Lumpkin (1994), Lebeau (1998, 2003), Marshall (1998), Mbambo (2002), Shapi et al (2009), Chinsemu et al (2009, 2010, 2011, and 2015), Shirungu (2010, 2015) and Cheikhyoussef et al (2011). Lumpkin (1994, p. 65) argues that local people visit traditional healers since they live in closer proximity to community members' homes than biomedical health care givers or facilities. In addition Shirungu (2010, p. 67) shows that local people make choices based on the type of illness they are suffering from and argues that the distance to health care facilities is just part of the problem. He maintains that the system that is chosen is not only determined by a patient's understanding of causation and the classification of the moral or spiritual aspects of the condition, but also by what a particular medical system has to offer and the patient's personal circumstances (Herselman 2007, p. 64).

Marshall (1998) noted that reliance on traditional medicine is high in rural as well as in urban areas. However, he argued that people are more knowledgeable about identities and applications of medicinal plants in rural areas than in urban areas. Cheikhyoussef et al (2011, p. 407) remarked that a total of 3,159 plant species have been reported in Namibia and a variety of

them are used by local communities for medicinal purposes. While a range of studies focus on what the Namibian government refers to as ‘indigenous’ knowledge in Kavango, there is still a huge gap in knowledge on the use of indigenous plants for medicinal purposes. In this regard, Cheikhoussef et al (2011, p. 416), remark that previous research done in Owamboland, Damaraland, Caprivi and Kavango have been biased since most of them mainly focused on food and other use while medicinal plant use aspects were not dealt with. The authors argue that research efforts on medicinal plants in Namibia have been skewed towards selected communities, especially the San communities. In contrast, areas like Kavango are under researched. I hope to help to address this knowledge gap.

2.7 Conclusion

This chapter has highlighted some of the major developments in the history of psychiatry and in particular how various scholars have theorised mental illness. Up to the present this has resulted in heated debates around universal mental health, notably at the intersection of anthropology and psychiatry. On the one hand psychiatry finds the DSM definition of mental health disorder across different cultures and nations useful in identifying, evaluating and treating mental problems in a global context, while anthropology questions biomedicine’s universal approach and argues that mental illness can be socially and culturally mediated, resulting in people expressing and experiencing mental distress differently, based on local contexts, which cannot be transported to other contexts. I find this debate important both in theory and practice as it provides insights into possible alternatives to the current crop of patent-protected remedies and trend-driven diagnoses. Furthermore, the current debates in literature demonstrate the ability to engage with both psychiatric categories and cultural concepts of distress offering a critically important bridge between the need to provide evident based care and the need to respect local knowledge and context (Kohrt and Mendenhall 2015, p. 37).

CHAPTER THREE

3 RESEARCH METHODOLOGY

3.1 INTRODUCTION

This chapter discusses the area of research with a brief historical background of its people, language, social economic status and clan affiliation, among other things. It mainly deals with the methodological strategies used in the study, the challenges faced in the field and how I as the local researcher positioned myself and negotiated my status, as well as the debate around home anthropology with regard to its methodological challenges, strengths and weaknesses (Forster 2015, p. 14). The methodological approaches used in this study were both qualitative and quantitative. The fieldwork was focused on observation and to an extent, participation in activities such as plants collecting and assisting with some of the tasks of trainee healers, including receiving visitors⁹. Semi structured interviews were conducted as well as three ethnobotanical surveys, as part of the quantitative methods.

In, my own case, the idea of ‘positionality’ refers to the constant shifting of social relations from being a local (native scholar) to that of a researcher in search for data from the study participants, the traditional healers (*Vanganga*). While I was in a position to take advantage of being a local ethnographer in accessing the field, building rapport and ultimately collecting the data, I was at times caught off guard when I had to decline taking part in some of the rituals which I thought might affect my social relations with the community members and with my family. This did not always resonate well with some of the healers but I was reluctant to undermine my standing in the community. This exposed me as primarily a researcher and a local person in search of knowledge which made me at times feel vulnerable: I had to reposition myself to affirm my identity as a local rather than as a researcher. The chapter also discusses some of the ethical issues encountered and dealt with in the field without undermining the participants in the study.

⁹ See chapter six on plants collections and chapter five for the ritual preparations.

3.2 The research area

The study was conducted in two Kavango regions (Fig. 1 below), which until recently were regarded as one. Following the 4th Delimitation Commission recommendations, as of August 2013 the regions were divided into Kavango East and Kavango West for political administration purposes. After independence the Namibian government maintained the colonial legacy of a divided people who lived based on their ethnic grouping in respect of people cultural believes and values. These principles were aimed at creating a discursive stability by balancing claims of universality and particularity by the various ethnic groups and their specific demands (Meinke 2015, p.43). At the same time the Namibian government listed ethnicity, tribalism, and regionalism as the main enemies in which its members and citizens in general should guard against (Akuupa 2011, p.42). As such the Namibian government preached a message of nationhood via the slogan “One Namibia One Nation” in order to define and determine belonging to national ideals of nationhood (Akuupa 2011, p.42).

Nevertheless, the making of Kavango as a political region did not have a greater significant impact on the practice of Traditional healing since; traditional healers and their medicine have not been well integrated with other health care systems to manage conditions like mental illness. As such traditional healers and their medicine in Namibia remain relevant to their local communities. In this regard, traditional healing is only celebrated or staged at national and international platforms as a cultural heritage which form part of national identity as well knowledge resource that once, appropriated and tested is subsumed under biomedical knowledge or commodity to be governed by the state (Meinke (2015, p.43).

Kavango means “a small place” in Rumanyo and is both the name of the region and a river situated in the northeast of Namibia (Shirungu 2010, p. 7). Currently the Kavango River serves as a border between Namibia and Angola. However, Shiremo (2015. p. 6) argues that until December 30, 1886, as per a German-Portuguese colonial agreement, the middle of the Kavango River was previously not regarded as an international border between Angola and Namibia. It was merely a lifeline and transport course for the people who lived alongside it.

Shiremo (2015) further argues that, after the Angolan civil war, Kavango headmen and -women started to claim their chieftainships and kingdoms on the Angolan side of the middle course of

Kavango River without encountering much difficulty from the Angolan government. There are currently 10 Kavango chiefs, five on the Namibian side and five on the Angolan side of the River (Shiremo 2015, p. 10). The Kavango chiefs in Angola have claimed areas in that country where their jurisdiction extends as per pre-colonial times. The people of Kavango live on both sides of the river and they move between the two countries for reasons such as health care, cultivating and harvesting or even visiting each other as family, brothers and sisters.

The largest urban settlement on the Namibian side is the regional capital of Rundu while the towns of Divundu and Nkurenkuru also have sizeable populations. The two Regions are mainly known for the Kavango River and its broad flood plains, which make the area considerably greener than the rest of Namibia. The Kavango River is central to the livelihood of the people and they depend on it for survival. In this regard the river is used for fishing, agricultural activities, gardening and recreation. Its water is also used for bathing, drinking and cooking.

The two regions are generally flat areas, with an elevation of 3,600 feet (1,100 m) above sea level and usually receive about 500 to 600 mm annual rainfall (Shirungu 2010). Due to high rainfall, patches of tall grass interspersed with bush, scrub and trees have developed, along with forests of teak, mahogany, and mopane trees. The two Kavango regions encompass 48 463 square kilometers and stretch along the river from Katwiti in the west to Divayi (southeast of Bagani) and to the Botswana border in the east over a distance of approximately 430 km. To the north-east, Kavango borders the Zambezi Region; to the west it borders the Ohangwena and Oshikoto regions (Shirungu 2010, p. 9).

Scholars who have conducted research in the area have shown that the Kavango people originated from Mashi, a legendary place situated along the Kwando River, in what are today areas of southwestern Zambia and southeastern Angola (Mbambo, 2002; Likuwa, 2005; Akuupa, 2006; Shirungu, 2010). The inhabitants are divided into five ethnically defined groups namely; *Hambukushu*, *Vagciriku*, *Vasambyu*, *Vambunza* and *Vakwangali* (Shirungu 2010, p. 10). People in Kavango speak different languages. In this regard, the *Kwangali* and *Vambunza* groups speak *Rukwangali*, and the *Vasambyu* and *Vagciriku* respectively speak *Rusambyu* and *Rugciriku*, which are dialects of the *Rumanyo* language. Since, 2002 the two groups have been

using the same text books in *Rumanyo* in schools to teach the respective dialects, which I learnt at home and in primary school.

I also speak Rukwangali, a lingua franca spoken in Rundu, the capital town of the Kavango, which I learnt as a youth in Rundu. Lastly, I also learned *Thimbukushu* during my regular visits to my paternal grandmother, an *Mbukushu* speaker who lived at Ngowa in Botswana. There are other languages spoken in Kavango, namely *Runyemba*, *Rushiwoke*, *Umbundu*, Afrikaans, English and Portuguese and two San group languages *Rucu* and *Rumbarakwengo* (Mbambo, 2002; Shirungu 2010). I conducted all my interviews in the five common languages spoken in the area even in cases where I interviewed someone who spoke other languages, such as *Rucu*, *Rumbarakwengo*, *Runyemba*, *Rushiwoke* or *Umbundu*, without encountering any difficulties since the latter groups were able to speak one of the four prominent languages of the area.

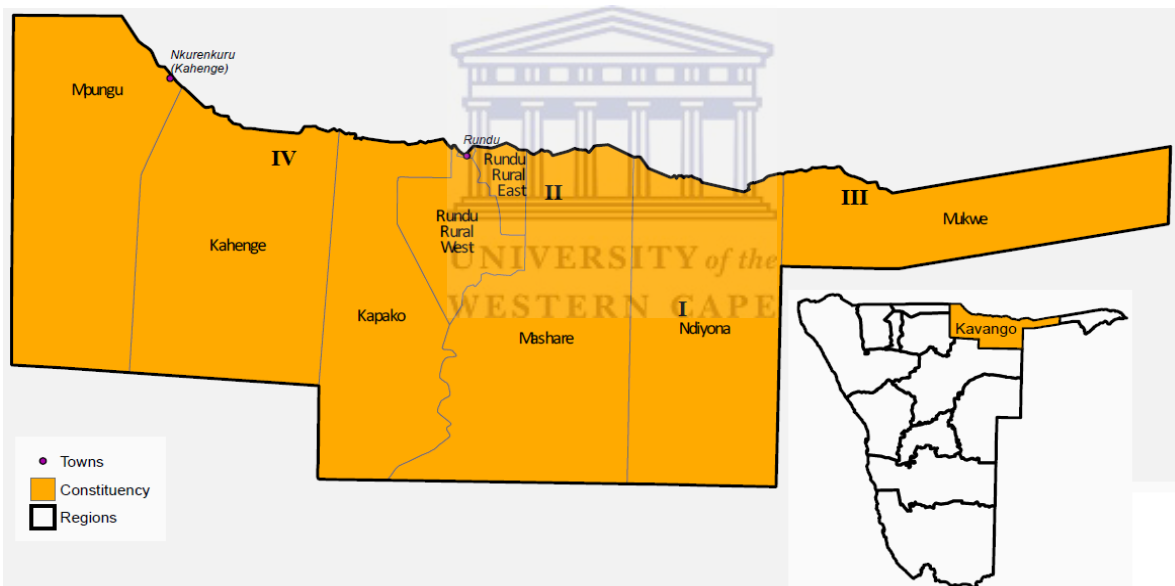


Figure 1 Map of Kavango regions showing study areas (adopted from Namibia Statistics Agency, (2011))

3.3 Research methods-Methods Belong to All of Us

Once the proposal was accepted and registered by University of the Western Cape’s ethics committee in 2014 I embarked on fieldwork over a period of 12 months in the two regions, namely Kavango East and West. This was done in different phases of three visits which I

discuss in detail under the section 1.3.3 “doing anthropology at home”. To recruit my participants I made use of a snowball sampling technique. Snowballing is a procedure when the researcher accesses informants through contact information that is provided by other informants (Chaim 2008, p. 330). In this regard the informants or participants refer the researcher to others, who are contacted by the researcher: they then, in turn, refer her or him to yet other informants. Chaim (2008, p. 330) notes that the evolving snowball effect, captured in a metaphor that touches on the central quality of this sampling procedure is that it has accumulative diachronic and dynamic dimensions and is arguably the most widely employed method of sampling in qualitative research in disciplines across the social sciences (Ibid). I relied on this sampling technique to gain access to my informants and enriched my sampling clusters accordingly.

Having interviewed a number of traditional healers in Kavango in the past I approached them first, to refer me to at least four other traditional healers. Before I started conducting the interviews I presented my participants with all the necessary information, explaining the aims of the research and obtaining their consent for participation in the study. Since I am fluent in in the four local languages spoken in the area, *Thimbukushu*, *Rugciriku*, *Rushambyu* and *Rukwangali*, I was able to do interviews and observations myself. I use the quote “methods belong to all of us” from Russell (2011, p. 2) to justify my use of both qualitative and quantitative research in this study as the best possible methods to collect the research data required for a doctoral study in anthropology on mental illness.

As is the norm among anthropologists, participant observation came up as an important method for the study. Yet this methodological tool could not provide all the answers to the questions I was raising, in particular those regarding the use of medicinal plants. To obtain the necessary information in relation to the latter I used a questionnaire survey, which in the past has been mostly used by sociologists, but has become more universal. In this regard, Russell (2011, p. 2) remarks, that while boundaries between the social science disciplines remain strong, those boundaries are less about methods and even less about content. He argues that the questions we ask about the human condition may differ across the social sciences, but methods belong to all of us since all disciplines have borrowed from each other, over the years. Anthropologists may make the most consistent use of participant observation, but that method turns up in political

science, nursing, criminology, and education. Equally, psychologists make consistent use of experiments and historians of archives, and anthropologists also use and contribute to the improvement of those methods (Russell 2011, p. 68).

I opted to make use of mixed methods because neither quantitative nor qualitative methods sufficed to answer my research questions and do justice to multiple viewpoints on the research topic. Thus, qualitative and quantitative research methods were utilised for this study. Pasick et al. (2009) argue that mixed research methods begin with the assumption that investigators try to understand social worlds and gather information based on the kinds of questions they wish to answer, as well as the theoretical orientation of the study.

Social inquiry targets various sources and many levels that affect a given problem (e.g., policies, organizations, family, individual). In this regard quantitative (mainly deductive) methods are ideal for measuring the pervasiveness of “known” phenomena and central patterns of association, including inferences of causality. Qualitative (mainly inductive) methods, on the other hand, allow for identification of previously unknown processes, explanations of why and how phenomena occur, and the range of their effects (Pasick et al., 2009). The use of mixed methods research involves more than simply collecting qualitative data from interviews, or collecting multiple forms of qualitative evidence (e.g., observations and interviews) or multiple types of quantitative evidence (e.g., surveys and diagnostic tests). Mixed methods research involves the intentional collection of *both* quantitative and qualitative data and the combination of the strengths of each to answer research questions (Greene et al 2007, p. 255). I opted to engage in mixed research methods, since they presented an opportunity to produce new insight through dialectic between methodologies and philosophical stances (Greene et al 2007, p. 256). Thus, I was pragmatic and chose to employ research tools that work, to answer and make sense of my research ‘problem’ and to answer my research questions. As such I opted for diverse approaches and valued both ‘objective’ and ‘subjective’ knowledge (Morgan, 2007, p. 46). While the idea of truly objective inquiry has long been understood to be unobtainable, striving for objectivity is useful. In practice, this means being explicit about our measurements, so that others can more easily find any errors we make. I employed qualitative and quantitative research methods to collect the data to improve the quality of the data and enhance

methodological diversity.

However, ethnographic method was the main method of this study. Because I am a trained psychiatric nurse I was aware of my own subjectivity, my professional values and the objectives I brought to this research process and how these affected my own perceptions and even my data collection. Being a psychiatric nurse and a fairly educated man may give me some power in certain situations, but it can also be to my disadvantage or marginalize me if traditional healers are not willing to participate in my study. According to van der Geest (2007, p. 7)

The research... implies constant self-reflection...The sharing of subjectivity, intersubjectivity – creates moments of recognition and the intuition that we have ‘grasped’ the other’s point of view, but those moments cannot be proved right or wrong; they are contestable.

Therefore, throughout my fieldwork I had an ongoing dialogue with my research participants (traditional healers) to ensure that as much as is possible, I have ‘grasped’ and made sense of their viewpoints. For example I spent a lot of time with the traditional healers trying to understand what mental illness means to them, in their own words. I even shared my field notes with them just to double check if we were on the same page and some of them corrected me where I misinterpreted their ideas or misspelt some category of mental illness or the name of the plants. The traditional healers were very serious about teaching me about mental illness and about their various healing methods. They often corrected me when I made mistakes. For example, during a visit in June 2016 Nawandambu, a female healer, was annoyed with me for mispronouncing *Ndjangura* - one of the local categories of mental illness in Kavango. She made the following remarks,

Maika you have been coming here for long now and you sound like white man. It is *Ndjangura* not *Tjangura*. Please write correctly if you are going to add my name on that paper.

The above remark by the healer partly speaks to the argument that anthropological knowledge

of a social group does not entirely rise from the anthropologist being or becoming part of the group studied, or getting the emic or insider perspective. It also derives from a (self-) problematization of the researcher's feeling of being part of that group (Tsuda (2015, p. 16).

I will turn to a discussion of 'native anthropology' shortly, but the point is that, while I positioned myself as a researcher and a student of the traditional healers, for the healers I was a local person, a native of Kavango who had been born and raised there. They expected me to look at the situation differently than any other 'outsider' researcher and to grasp things quickly. In other words traditional healers were not forgiving when I made mistakes like in the case above.

A total of twenty five (25) traditional healers were interviewed, three (3) ethno-botanical surveys were conducted and five (5) of the traditional healers were closely studied. To do the latter I used ethnographic methods. I spent a lot of time with them to enable me to give 'thick descriptions' (Geertz 1973) of their everyday lives and the ways in which they understand and treat people with mental illness. I use the use notion of thick description to not only interpret traditional healing as a social and cultural practice but to also illustrate its continued importance to the people who make use of it. During my first contact with a healer I started by asking simple routine questions concerning demographic background such as age, level of education and the category of healer into which he/she belonged, training and way of entry into the profession. As time passed I slowly initiated discussions around mental illness and later moved to the healing activities: such as methods of diagnosis and treatment, name of the plants used, preparation methods etc.

Although I am not a traditional healer, I am recognized by them as a kind of healer too. Nevertheless I came to them as a student of their knowledge and skills, and as such I spent a great deal of time with five traditional healers, observing their diagnostic and treatment methods and discussing it with them. As much as possible I participated in their activities, including collecting medicinal plants in the veld and participating among other things in the ritual healing dance for a "mad" person.

Qualitative research methods enable researchers to understand processes, especially those that emerge over time, provide detailed information about settings or contexts, emphasize the voices of participants and provide a depth of understanding of concepts (Creswell et al 2011, p. 67). Apart from participation and observation (in the case of case studies), I conducted in-depth interviews with traditional healers, as well as semi-structured interviews, to explore similar topics with a large number of traditional healers. With their permission I used tape and video recordings, and cameras, in my data collection. I use pseudonyms throughout the thesis.

Currently there is no official record of the number of traditional healers in Kavango, which made it difficult to select the sample. However, my sample is informed by the field trip report for an ethnobotanical survey¹⁰ in which 176 traditional healers in Kavango were interviewed. In this regard, about 30 percent of traditional healers indicated that they can treat mental illness; hence I opted to interview half of them. Therefore, the data that I collected is reliable and representative of reality on the ground.

Quantitative data has the multi-faceted potential to provide measurable information, to help establish (probable) cause and effect. It yields efficient data collection procedures, creates the possibility of replication and generalization to a population, facilitates the comparison of groups, and provides insight into a breadth of experiences (Creswell et al 2011, p. 5).

Three ethno-botanical surveys were conducted between March 2014 and July 2015. During the surveys structured questionnaire and oral interviews were used to collect the data. In this regard, interviews were conducted in the four local languages spoken in the area namely; *Rukwangali, Rushambyu, Thimbukushu and Rugciriku*. It must be noted that all interviews were recorded using a voice recorder after seeking permission from interviewees. Plant specimens were also collected and preserved in a plant press as voucher specimens for submission to the NBRI National Botanical Research Institute (NBRI), Windhoek, Namibia¹¹ for scientific identification. Each of the plants was also assigned a voucher specimen number, a voucher

¹⁰ Cheikhyoussef, A., Shirungu, M., Du Preez, I., and Mumbengegwi, D., 2013. Ethnobotanical Knowledge in Kavango Region; a Field Trip Report. Multidisciplinary Research Centre (MRC), University of Namibia, Windhoek, Namibia.

¹¹ See chapter six on the use of medicinal plants to treat mental illness in Kavango.

specimen collection form was completed and photos were also taken and submitted with the specimens.

3.4 Doing anthropology at home

3.4.1 Entering the field

On 12 March 2014 I drove from Windhoek, the capital of Namibia, to Kavango. Since my PhD study was partially funded by NRF I hired a 4x4 Bakkie from the University of Namibia (my employer, popularly known as UNAM), which I used throughout the fieldwork. Upon my arrival in my home town Rundu, the capital of Kavango East region, I decided to overnight in town after a drive of more than 600 kilometers. Friends and family members were keen to know about the purpose of my visit and many assumed I was on official duty since I was in the UNAM car. On that evening while having dinner at my sister's house, sis Connie asked me.

ShaMbusha Vinke Nani Munakuyaruwana ovyo munayana Lihauto lyaviruwana? (the father of my Namesake what is that you are going to do since you came with a car for work?)

I smiled and replied;

Kuna kuya ruwana makonakono gha likusho lyaghu ndokatora wande vyakuhamena kughupurumuki. (I am going to conduct a research for my doctoral studies on madness.

Sis Conny;

Naaaaaaani! ShaMbusha ovyo nevidito ngoli. Ghupurumi nka munakuya kushonga?
Hehe (wow! The Father of my name sake that is very complicated you are going to study madness. Hehe).

People in the house were amazed by my research topic and my cousins made fun of me. My cousin Kamwaye (not her real name) said:

Maika, unless you are also mad or how come you want to study madness?

The following morning I drove to Kaisosi Clinic to greet my old friend bra George and to show appreciation of past support and let him know that I am around with research work. When I was doing my fieldwork for my MA Thesis in 2009 Kaisosi Clinic was my main duty station as well as my temporary home for three months. When I entered the clinic I was warmly welcomed by staff members, and some new faces to whom bra George introduced me. I told them about my visit and they were laughing non-stop as they wished me good luck with my studies. Bra George cautioned me to be careful and not go ‘mad’ myself at the end of my studies. Thereafter I drove for an hour to Kangweru Village about 100 km east of Rundu.

It was raining and the roadside plants were green and the grass was long - the road was wet with lots of animals along it and I had to drive slowly and carefully. I went to my parents’ house and I found my mother, bra Anse and bra Hesy at home waiting for my arrival. All of them were happy to see me and as I sat down I greeted all of them and then my mother asked me how I was doing?

Mum: *weni nawa ndi?* (How are you doing? You well?)

Mike: *yii vavo nawa* (yes I am well and yourself)

Mum: *Natwe ntarara yetu tupu* (We are also doing very well)

The above type of greetings is known as *kukunda* among the five ethnically defined Kavango groups I discuss under the research area section 3.2. It is local cultural practice that the younger person is obliged to greet the elder member of the family first. However, it is a Kavango tradition that the younger person should wait for the elder person to ask them how they are doing, about their health and so on, and not the other way around. Nevertheless, seniority is not only determined by age but by clanship. In this regards clanship affiliation among the Kavango is acquired through their mothers and not through their fathers. Thus, the Kavango communities are matrilineal people (Shiremo 2010, p. 16). As such a person can be younger by age but senior in terms of clanships and will then have the authority in *kukunda* (greeting) of the person within the same clan. Hierarchies of seniority exist within each clan by virtue of matrilineal relations. For example my father belongs to the *Vakayovhu* clan (Elephant) while my mother belongs to the *Vakandjadi* clan (Hawk). Since Kavango people follow a matrilineal kinship

system, I therefore belong to the *Vakandjadi* clan (Hawk). My clan affinity to the community helped me to easily built rapport with the participants however; it did not guarantee smooth access to the information. As Akuupa (2011, p72) argued that clan affiliation (*ekoro*) may influenced the access to the field, but it can also have some limitation in data collection to produce the expected results due dynamic of power relations and authority that come with it. In my case I used clan affinity as an icebreaker to not only starts a conversation but also to build a trusting relationship as I will show later in this chapter. See the table below indicating the clans that are found in Kavango across all the five ethnically defined groups.

Table 1 Lists of *Vakavango* matrilineal clans source Shiremo (2010)

Clan Name in English.	Vagciriku	Vashambyu	Vakwangali	Vambunza	Hambukushu
1.Cattle	Vakangombe	Vonkwangombe	Vakwangombe	Vakwangombe	Hakathimu
2. Falcon-Hawk/Rain	Vakandjadi	Vonkwandjadi	Vakwanzadi	Vakwanzadi	Hakamvhura
3. Lion	Vakanyime	Vonkwanyime	Vakwanyime	Vakwanyime	Hakanyime
4.Parrot/Frog/	Vakankora	Vonkwankora	Vakwankora	Vakwankora	Hakayembe
5.Famous/Frog	Vakafuma	Vonkwamfuma			Hakayembe
6.Buffalo	Vakanyashi	Vonkwanyashi	Vakwanyatji	Vakwanyatji	Hakanyatji
7.Elephant	Vakayovhu	Vonkwayovhu	Vakwanzovu	Vakwanzovu	Hakayovhu Hakambara
8. Copper	Vakangondo	Vonkwangondo			Hakangondo
9. Hyena	Vakashipika	Vonkwashipika	Vakwasipika	Vakwasipika	
10. Locust			Vakwambahu	Vakwambahu	

11 Crocodile			Vakwanangan du	Vakwanangandu	
12 Zebra					Hakasheya



The above table shows that many of the clans transcend the five Kavango communities with the exception of s the *Hakasheya*, *Hakambara*, *Vakwambahu* and the *Vakwanangandu*. This fact signifies the close links between the clans across the Kavango Region (Shiremo 2009). In the next section I illustrate how I went about locating traditional healers.

3.5 Locating traditional healers

Just like my arrival at my sister's house in Rundu, my mother and my siblings were fascinated by my interest in studying traditional healing, especially my focus on madness. The following morning my mother responded to my question, if she knew of a traditional healer in the area:

In actual fact they are very few genuine healers these day's most of them are chance taker and some of them like money too much. But if it was those days, the times of *Nkurunganga* Kamangu¹² my son you were going to learn a lot about traditional healing - but go to Nawandambu and Shamwaka those one are ok.

After breakfast I asked my younger brother Anse and cousin Shindimba to accompany me to the field and to assist me with collecting plants. In the car my cousin said to me:

So we are going to see Shamwaka yoo I am scared and excited at the same time. I heard a lot about that man and I am happy I am going to meet him in person but people might think we want to become witches.

I assured him all would be well and that he should not worry or be afraid. I then asked him why people should think we were going to become witches if we were visiting a healer. Why can't they think for example that we are sick and need help or we are doing research like in our case? While smiling he replied to me:

¹² The word *Nkurunganga* can be directly translated to someone who is senior but in the case of the traditional healers it could mean specialist and I will use it as such throughout the text. While Kamangu was a prominent traditional healer who lives around the 1950s and his name was mentioned by many people including some of the traditional healers that I interviewed.

You know very well that every traditional healer is a witch, it is an open secret. It takes a witch to see another witch and by the way most people go see traditional healers at night not during the day. But let me not say all these things as I heard that those people (traditional healers) can hear everything that you say about them and he might ask me about it

My cousin's remark speaks to the ambiguity of traditional healing –people believe it can heal and protect against e.g. witchcraft, but it can also potentially harm, e.g. through preparing or providing *muthi* (medicines, potions etc.) for bewitchment (Asforth 2005, p. 67). Asforth who studied witchcraft in Soweto, South Africa, argued that witchcraft and the related aspects of spiritual insecurity can cause dangers, doubts, and fears to arise among local people. This leads to a sense of being exposed to invisible evil forces – such as witches (Asforth 2005, p. 67). He noted that nobody can understand life in Africa without understanding witchcraft and the related aspects of spiritual insecurity. Asforth opined that to understand witchcraft, one must attend to gossip because it cements and circumscribes social networks through the sharing of secrets about witches - who are, in turn, believed to possess secret knowledge (Ibid).

Since I was studying traditional healers the idea of witchcraft was inevitable: certain people in the community were labelled as witches by the healers but, at the same time, traditional healers were also feared for their supernatural powers which can protect or cause harm. As a local researcher I was cautious not to become embroiled in activities that may cause suspicion about me (as a possible witch) among my family and community members.

At around nine in the morning I arrived at the residence of Shamwaka. Since I had visited this healer in 2013 during the ethnobotanical survey I knew where his consultation area was, so I drove there. Two of the healer's assistants known as *Tungagwena's* welcomed us: I had met both the previous year. They informed me that the *Nkurunganga* (specialist traditional healer)¹³ Shamwaka would be with me shortly. After 30 minutes he emerged from his homestead and we all stood up and greeted him: then he said to me

¹³ See chapter four on the different types of healers in Kavango.

Shamwaka. *Nawa ngoli* (How are you)

Mike: *Nawa* (I am fine)

Shamwaka: *Weni omo tuhvura kumuvatera* (How can I help you?)

The second question gave me an opportunity to explain the purpose of my visit. Although we had met before I thought it was appropriate to introduce myself properly again.

Mike: My name is Shirungu Michael from the *Vakandjandi* (Hawk) clan and the son of *Vakayovhu* Elephant clan. Our family house is near Nyangana Hospital at Kangweru village and I am here to do a study on how do traditional healers understand and treat mental illness here in Kavango. I plan to do this fieldwork for one year and the findings will be used to write up my doctoral dissertation, so I am here as a student from the University of the Western Cape and I want to be your student of traditional healing. I want to interview at least 25 traditional healers and spend some time with them, observe their treatment, ritual dance and where possible I will participate.¹⁴

I concluded by saying that I was not sent by anybody but I was doing this on my own so I did not have any money to pay or give as compensation. Shamwaka smiled, looked at me and said:

Well so you are from the *Vakadjadi* clan however you are our son I am also form the *Vakayovho* clan. But you must remember traditional healing is deep stuff it is not like the way you go to the university and you start learning. I do not have any problems but you have to prepare yourself mentally if you are really serious like what you are saying. But today I will be going to town Rundu later in the afternoon.

I subsequently gave a much broader explanation of my study, explained ethical issues and the use of informed consent. The healer verbally consented to participation and I audio recorded this. What I want to highlight here is how I positioned myself in the study as a researcher,

¹⁴ My first introduction later became a norm/routine as I used this introduction with all the traditional healers that I have interviewed.

student and a *mundambo*¹⁵ (local person via the notion of clanship). My approach was a deliberate and firstly, informed by my knowledge as a local person born in the area secondly, from my previous experience in doing fieldwork in the areas dating from 2009 until present, and lastly my theoretical body of knowledge as an anthropologist.

It is a Kavango cultural practice to greet an elderly person ‘properly’ through the process known as *kukutongonona*¹⁶. This is crucial and guides your future engagements, meetings and relationship. The healer was from the Elephant clan which means his mother belonged to this clan, as did my own father - on this basis a clan tie/affinity was established and I could build a trust relationship on this with the healer, as I will show later in chapter.

From my previous experience I learned that it was important to state your position, particularly your main aim, duration of your visit and expectations so that your participants did not make assumptions or speculate about your intentions. I also learned from my previous involvement with the healers that some of them did not like it when a researcher moved from one healer to another, especially if they were in close proximity. Thus I emphasized that I would interview other healers as well. This would lessen potential tension in the future when I visited other healers. Equally, I was emphatic that I was a student and my aim was to learn, so that the healer should not have any expectation of payments or any other tokens of appreciation. Lastly as an anthropologist I am aware of what is termed “native anthropology” which could roughly refer someone studying his own culture, which might raise some methodological issues.

3.6 Being a native researcher: positioning myself

There are a number of writings on the differences between methodological approaches of studying your own cultural setting versus studying the ethnographic ‘other’. Some suggest that there are no essential differences; both involve the same methodological commitments and challenges, while others question the merits of each, pointing out strengths and weaknesses

¹⁵ *Mundambo* is someone who is familiar, known and accepted to the local people in an area (shirungu 2010)

¹⁶ *Kukutongonona* is an extensive introduction which does not just end with the name, but with the presentation of your extended relatives including your parents, grandparents and previous domiciles Akuupa (2015)

(Forster, 2015, p. 14).

One of the major critiques of 'home' anthropology is the notion that an insider cannot detach enough from their own cultural understandings to see the underlying patterns that are taken for granted in everyday interactions, which might be easier for an outsider to spot. Also, the insider/native anthropologist is expected to know the norms and would be less likely to be forgiven for transgressing them (Mead 2000; Douglas 2002).

I had to be doubly aware and very self-reflexive. I took note of every possible little detail which I would see, hear and touch - and I asked questions all the time. I developed an interest in the traditional healers' diagnostic tools, described in Chapter 4, which are regarded as highly secretive instruments. Because I took nothing for granted I was later allowed not only to observe but also to touch some of these diagnostic tools which is very rare for a local person.

Nevertheless, as a local anthropologist I could tap into the advantages of doing fieldwork at home and the cultural competence I already had - particularly with regards to language. I was knowledgeable in both the speech and non-verbal communication of my participants and took advantage of this in building rapport and trust, as I illustrated in recruiting my first participants. They later became five case studies from the total 25 traditional healers with whom I did in-depth interviews. Forster (2015, p. 15) remarks that full communicative competence affords native anthropologists a faster ability to build rapport and deeper understandings which can increase one's flexibility, access, and ability to collect data in the field. Foster's argument should not be taken lightly as I was able to conduct two interviews on my first day in the field which is not usual in many cases. Throughout my fieldwork I met only one healer who was not immediately willing to speak to me: since he needed to consult and get permission from the ancestors first. I took the cellphone number of the traditional healer who refused me an interview and made some attempts to arrange for an interview but it never worked out. On two occasions he told me to wait until the ancestors gives him the permission and he was going to inform me telephonically but that did not happen. However, his refusal did not affect my data collection process since they were a lot of other traditional healers who accepted me as a Kangangwena (Trainee healer).

I did not have to use translators, as I heard and comprehended everything that the traditional healers were saying. However, Delamont and Atkinson (1995) warned that cultural competence may complicate the basic task of choosing what to leave in and what to leave out of field notes, let alone the amount of clarifying and sifting of data necessary to do good analysis. In this regards, while I have gathered much data via fieldnotes, recorded interviewees, used videos and photos, I always assessed my notes against my aim and objectives of the study on a daily basis to make sure I was collecting relevant, reliable and valid data and to constantly check for saturation.

Like all anthropologists I also faced challenges in the field. As I have mentioned above I had to constantly negotiate my positionality, to strike a balance between being an emic researcher and a local person. I had been cautioned on the kind of relationship I should try to build with the healers so from time to time I took family members with me on my visits. This was to ensure that my family also understood my work and did not become suspicious of me, as somehow having become entangled in a net of discourses concerning misfortune and witchcraft (see Fravret-Saada 1977; Niehaus 2013) through my research and work with healers: who are symbolically ambiguous since they, and their work, can involve healing, as well as dealing with, or bringing about misfortune or bewitchment on behalf of clients. Psychiatric problems are also frequently associated with witchcraft, as I will discuss later.

This was one major shortcoming of being a local anthropologist for me in this study – the very real possibility of being suspected of witchcraft myself. As a result I did not attend healing rituals that were done at secret places even when I was invited to do so. Attending such events would raise suspicion among the community members, especially my family. As a result a few of the traditional healers did not regard me as a student of their craft: especially when I shied away from observing or taking part in certain procedures or events such as rituals healing that were done in isolated and secret places.

Overall traditional healers were aware of my concerns (of being accused or suspected of witchcraft by others) and often asked me if I was comfortable to attend and/or participate in

their rituals. (See chapter six in this regard). Such moments highlighted my position as a researcher. However, often my presence was seen as that of a trainee and not noticed or did not matter. The healers went on with their routine work as if I was not present. There accordingly was a complex and constantly shifting relationship between myself and the traditional healers: characterized by a swift transition from being an ‘insider’ to being an ‘outsider’ and researcher. I had to adjust my positionality in the field all the time.

As indicated above, in general traditional healer took me as one of their trainees, a student. Yet there were moments when I was felt or seen as an outsider and a researcher. Thus, I was both partial outsider and partial insider in a way that Abu-Lughod (1991) referred to as being a halfy/halfies (Shirungu 2010, p. 23). Nevertheless, as a local person, a native, I was easily accepted by the traditional healers and most of them were willing to share their knowledge and skills with me.

Therefore, this thesis carries a great responsibility for me – both as a local and as an academic. I am both informed by my ‘insider’ knowledge and position as a local man from Kavango, well positioned to speak to the local context by taking traditional healers’ way of knowing serious. I try in my writing to articulate and bring out traditional healers’ points of view on the subject of mental illness. As an academic I similarly spent a lot of time defining concepts to derive meaning and to engage fully in the global debate on mental illness.

I do not regard the participating traditional healers as mere informants or useful tools for gathering information. As a group, traditional healers are increasingly becoming the subject of studies. Some are critical of the ethnographies written about them which did not engage in a dialogue with them but tried to only address academic audiences (Tsuda 2015, p. 336; Kuwayama 2003, p. 10). While I did not have problems in accessing the field and building rapport I was faced with some ethical dilemma which I had not anticipated. In the next section I will deal with some of these encountered in the study.

3.7 Ethics statement and considerations

Research needs to take into account the question of ethics and as such it must be authorized personally by the concerned individual or institutions that are empowered to protect the rights of e.g. vulnerable groups. Before I commenced with my fieldwork I applied for ethical clearance from the Faculty of Arts Research and Ethics Committee, and the Senate Ethics Committee of the University of the Western Cape. My application was approved in 2014. In addition I followed the Ethical Guidelines of Anthropology Southern Africa and the international Ethical Guidelines for Social Science Research in Health. As a nurse practitioner I also adhered to the principle that my study should not harm the participants in any way, and throughout my fieldwork I respected and protected the rights and dignity of participants.

Although my study focuses on mental illness, I did not interview people who are mentally ill: since by law they could not give their informed consent to participate in the study (Harfried 2012, p. 444). My research participants were traditional healers who took part in this study on a voluntary basis and were asked for their informed consent. The latter was done after I outlined and explained the study, its aims, the expectations they might have and what I wished to learn from them. I explained to them verbally as well as in writing in four of the local languages spoken in Kavango. As I have shown above, most of my participant refused to sign the consent forms, I took consent, which was recorded. I use pseudonyms to protect the identity of participants. To ensure total confidentiality I keep all collected information safely locked away.

Because I am a psychiatric nurse I did have problem in cases where mentally ill persons were maltreated or when they presented with severe and distressing symptoms. Based on my clinician experience as a psychiatric nurse, I advised the traditional healer and the sick person's family of the availability of medical treatment for such illnesses and the potential benefits of taking the afflicted person to the hospital. I did, however, not interfere with the final decision taken by the traditional healers or the family.

My ethno-botanical questionnaires included a prior informed consent document and memorandum of understanding as well. A research permit was obtained from the Permit Office of the Ministry of Environment and Tourism in Windhoek for the collection of medicinal plants. A benefit-sharing agreement (see Appendix three) was drawn up with participants,

stipulating that the plant material was the property of the provider and made available as a service to the research community at UWC. It would be used for research only, or not-for-profit research purposes. The material would only be made available to other researchers with the approval of the provider. For study purposes I put in place procedures of various informed consent (as outlined above) and these are attached as appendices. I did this formally to address ethical issues, property rights and benefit sharing agreements with the knowledge holders in this study. The Convention on Biological Diversity (CBD)¹⁷, for instance, requires that prior informed consent be obtained from local communities before accessing their traditional knowledge, innovations and practices. The informed consent process guided me on essential steps to obtain a consent process ethically and successfully, namely, legitimized consent, full disclosure, adequate comprehension and voluntary agreement between knowledge holders and myself.

3.8 Ethical concerns in the field

It is important to note that there are stories I heard and information I was given during fieldwork which I choose not to include in the study. This is due to its sensitive nature or at the request of traditional healers themselves.

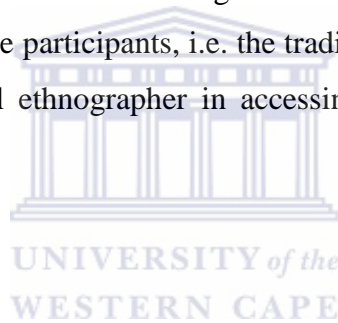
Some traditional healers requested that I use their full names in the thesis so that people will know that they provided the knowledge. Although they claimed to have nothing to hide, I found some of the material too sensitive to be attached to a particular person, especially when the narrative on how they became traditional healers apparently involved human sacrifice (I discuss aspects of becoming a traditional healer and diagnostic methods next in Chapter 4). Most of the traditional healers claimed to know all the witches in the villages and they shared the latter's names with me. I nonetheless chose to not reveal them. Another ethical concern related to a healer with whom I worked. He was paid to 'eliminate' an individual -identified via his *katemba* - as being responsible for bewitching and killing a certain man. The latter's family had consulted the healer after his death – they suspected witchcraft and wanted to determine who

¹⁷ Basel Convention (1992) *Basel Convention on the Control of Trans-boundary Movements of Hazardous Wastes and Their Disposal*.

had bewitched the deceased and caused his death. The family wanted the ‘witch’ to be punished. I withdrew from any interaction with the healer concerning this ‘case’.

3.9 Conclusion

In this chapter I have pointed out theoretical and practical methodological approaches used in this study, in particular various qualitative and quantitative methods. The principal fieldwork methods were to gather ethnographic data focused on observation and to a certain extent to participate in some of the activities such as collecting plants and receiving visitors¹⁸. Semi structured interviews were conducted as well as three ethno-botanical surveys, as part of the quantitative methods. The chapter raises the idea of ‘positionality’, which in this regard refers to the constant shifting of social relations from being a local researcher (native scholar) to being a researcher obtaining data from the participants, i.e. the traditional healers (*Vanganga*). Hence, I took advantage of being a local ethnographer in accessing the field, building rapport and ultimately collecting the data.



¹⁸ See chapter six on plants collections and chapter five for the ritual preparations.

CHAPTER FOUR

4 TYPES OF THE VANGANGA, DIAGNOSTIC METHODS AND THEIR LEGAL STATUS

4.1 INTRODUCTION

Traditional healers in Namibia form part of a local health care system - which historically has been unregulated and free of legislative interference. Over the years there have been calls for the recognition and regulation of traditional healers and -medicines, but to date such recognition and regulation has been infrequent, insufficient, and contentious (Rautenbach 2008, p.2). Namibia's existing health legislation does not provide a legal or formal framework for traditional healers. In this regard, the Namibian Allied Health Professions Act, 2004 (Act No. 7 of 2004), which sets out registration and licensing requirements to control the practice of the "allied" health professions does not include traditional healers in this definition. After Namibia's independence in 1990 the Namibia Eagle Traditional Healers Association was created to regulate and register traditional healers in the country, but it was later put on hold indefinitely (Lumpkin1994; WHO 2001).

Contrastingly, in neighbouring South Africa, for instance, there has been a slow process of incorporating traditional healers as allied health workers following the Traditional Health Practitioners Act which was promulgated in 2007 (Gibson, 2016, p. 2). The Act defines the categories of healers that will eventually be registered. For this purpose, inter alia, an Interim Health Practitioners Council was inaugurated in 2013 and one of its tasks is to set up a regulatory framework for traditional healers (Gibson, 2016, p. 2).

For Namibia it will accordingly be important to ascertain various categories of healers, their paths of entry into the profession, diagnostic processes and their legal status. In particular this chapter examines the notion of *nganga* (*singular*) *vanganga* (*plural*) (traditional healers) in Kavango and argues that *vanganga* should be understood to include three concepts, namely *kangangwena* (assistant traditional healer), *nganga* (general traditional healer) and

nkurunganga (expert traditional healer). I will show that no individual can become a *nganga* or *nkurunganga* without first being a *kangangwena*. A person can progress from *kangangwena* (assistant traditional healer) over an unspecified period, say five to ten years, but some never graduate to the next level of *nganga* or *nkurunganga*.

4.2 Various categories of traditional healers (*vanganga*)

Traditional healers are ubiquitous and play a crucial role in providing services to the majority of the local population. Freeman and Motsei (1992, p. 188) noted that traditional healers represent an untapped resource which has enormous potential to treat many prevailing illnesses and to educate people in all aspects of preventable conditions. The World Health Organization (1978, p. 12) defines “traditional healer” as:

a person who is recognised by the community in which he/she lives as competent to provide health care by using vegetable, animal and mineral substances (and other methods) based on the social, cultural and religious background, as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability.

Thornton (2009, p. 17) viewed the term ‘traditional healers’ as a misnomer. He opined that the term ‘tradition’ suggests an unchanging conservation of past beliefs and practices, whereas the term ‘healer’ is seen as someone who practices some version of physiological therapy aimed at organic disease. He further argued that - although traditional healing may resemble the older ‘traditions’ reported in the early ethnographies like divination - it has been affected by multiple roots that extend across time, cultural settings and languages (Thornton 2009, p. 17).

Similarly in Kavango traditional healers have been exposed to a wide range of traditional healing practices and influences from the neighbouring cultural groupings and they have borrowed some of the ideas and medicines for use in their own healing. A number of studies have been done on traditional healing in Kavango including the work of Shirungu (2015, 2010), Chinsemu (2015), Lindhout (2000), Mbambo (2002), Lebeau (1998) and Lumpkin (1993). In

general, categories of traditional healers in Kavango can be grouped according to their specializations such as *Nganga wandandani* (herbalists), *Nganga wamahamba* (diviner-herbalists), and *Nganga wakatamba* (diviners) (Lindhout 2000, p. 89; Mbambo 2002, p. 180). This categorisation is problematic since it is difficult to make any distinction between those three categories and in many respects they overlap. For example, under the above categories Mbambo (2002, p. 180) distinguishes among the traditional healers more extensively:

- i. *Nganga wandandani* (herbalists) –Specialize in various herbs/ plant medicines and mainly use plants and roots as medicine.
- ii. *Nganga wamahamba* (diviner) – Specialize in fighting off sickness caused by witchcraft or ancestors. They use rituals and herbal medicine to diagnose and treat the afflicted.
- iii. *Nganga wakatamba* (diviner-herbalists) - Seek to diagnose or resolve problems via the technique of the *Katamba* and use herbs/ plant medicines to treat patients. These healers consult with spirits, who may identify the type and cause of the illness.

Traditional healers in Kavango do not all perform the same functions, nor do they all fall into the categories above but rather have their own fields of expertise, their own methods of diagnosis and treatment with distinctive features. Their roles overlap considerably (Truter, 2007, p. 58). I found that diviners who are specialists in divination, for instance, also use herbal medicines as part of their treatment. Equally, the herbalists who specialize in herbal medicines, used some sort of divination technique in their diagnosis process. For me the above three categories are useful but they have limitations which make them difficult to distinguish. Therefore, I would like to propose a framework to categorise and classify distinctions between traditional healers in Kavango as *kangangwena* (assistant traditional healer), *nganga* (general traditional healer) and *nkurunganga* (expert traditional healer). Thereafter, training labels such as herbalist, diviner, diviner-herbalists, faith healers, traditional birth attendant can then be attached to them, based on their level of training as discussed below¹⁹. This framework will be helpful to determine not only the level of training and knowledge but also the area of specialisation.

¹⁹ See 4.4.1, 4.4.2, and 4.4.3.

4.3 How to become a traditional healer (*Weni vaturanga ghunganga*)

I present three narratives of traditional healers on how they became traditional healers as a point of reference and thereafter discuss the idea of a *nganga* in more detail.

Case one: Interview with TH1.²⁰

Actually becoming a *nganga* is not something that can just be accorded to anyone. *Nganga* skills have to be learnt, like a person who is at school. The starting point is to learn about the different kinds of herbs/ medicinal plants used to manage various illnesses. That is how I started. I learned from a friend for eight years before I started working on my own. So the first phase is about mastering various medicinal plants and their usage which is a long process. Once a person has acquired good knowledge about medicinal plants then he/she can go into the second phase. The second phase is about understanding how the spirit works which is the next level in traditional healing. At this level the *Nkurunganga* will ask you to look for a cow, two chickens and the skin of a wild animal such a leopard or cheetah. Once you have acquired all these items then a big ceremony local known as *liware* will be performed and anyone in the village is welcome to witness the ceremony. In many cases people will come in big numbers to witness the ceremony, so that they could see what the *Nkurunganga* is doing: after all, they are the people that you are going to treat. During the ceremony the cow and the two chickens are slaughtered and have their hearts removed. Then the healer will insert two needles at the tip of each heart, of the cow and the two chickens. The person who wants to become a traditional healer must swallow the three tips of the three hearts while they are raw, but without the needle. Another thing that needs to be swallowed is the substance local known as *ndondo twalinongo* and *mutehenena* together with one of the chicken hearts. Altogether it is known as *Ndondera*, which will open your eyes to the spiritual world so that you will be able to see and identify witches. At times, in the absence of *katemba* you will be able to diagnose illness, by looking at the person. I was given the *katemba* of *Mbinga* (horn of the cattle) and in that opening space of the horn the healer put some medicinal plants, *mutehenene* and the arm of a chameleon. In the past the *nganga* used

²⁰Interview with a Male Traditional healer at Shahvura village on 05 November 2014

to put the arm of a human being but, nowadays people do not do that anymore because this process can wipe out family members who are used in the ritual as the katemba needs to be rejuvenated from time to time.

Case two TH2²¹

I became a traditional healer at a tender age after I was treated by a traditional healer following my sickness. I went mad myself and that is how I came to know how to treat mental illness. I ran to the river and went under water for about three hours without my knowledge since I was mad. After I came out of the water I ran back home and I refused to eat or drink anything. Later I was taken to a traditional healer who treated me. After I have recovered I learned about the plants and later I got my katemba of linguni which until today I use it to diagnose sick persons. I did not sacrifice anybody. My katemba is just made out (of) medicinal plants and some wild animal parts.

Case three TH3²²

My father was a traditional healer but he died while I was still very young. I became a traditional healer after I was bewitched and my family took me to a traditional healer near Ruta in Zambia where I was treated. After I recovered I became interested in traditional healing and the traditional healer who treated me agreed to teach me. But for me to be the Nkurunganga today I have consulted more than ten traditional healers to gain all this experience. Initially this healer was too reluctant to go into details as to how he came a healer in the presence of his assistants, but later when it was only the two of us he started to open up. Unlike the first healer who does not sacrifice humans for his diagnostic tool, this healer admitted that he uses human beings for his diagnostic tool. He also told me that his ceremony of becoming a healer was done at a secretive place in Zambia in which he also sacrificed a close family member in 1982. For example he once told me his katemba diagnostic tool struck and injured him on his right foot because he wanted to assist a client free of charge, since the family did not have money. At the time of my research this healer had about five boys who worked for him as *tungangwena*

²¹Interview with a female traditional healer at Divava villange on 10 June 2014

²²Interview with a male (specialised traditional healers) at mbunya villange on 14 March 2014

(assistant healers) and his three wives who take care of female sick persons especially on reproduction related-illness. This healer has more than ten traditional huts where sick persons are admitted.

4.4 The idea of a *nganga* (traditional healer) in Kavango

4.4.1 *Kangangwena* (Assistant traditional healer)

From the three narratives of the traditional healers above, there were three noteworthy concepts around the notion of a *nganga* which emerged. I also came across it during fieldwork, namely the categories *kangangwena* (assistant traditional healer), *nganga* (general traditional healer) and *nkurunganga* (expert traditional healer).

In Kavango any person who is interested in traditional healing and medicine can become a *kangangwena* to the *nganga* or *nkurunganga* as provided the *nganga* accepts that person as his/her *kangangwena*.²³ However, in some cases one has to be nominated or chosen by the spirits of the *vadimu* (ancestors) like the two healers in the above case studies. Nonetheless, training as a healer (1) out of interest or (2) as a result of the ancestors' calling gives a Kavango traditional healer the same healing powers and status among the local people. As such, a person can become a *kangangwena* through a calling by the ancestors (*vadimu*). In this regard, there is a belief among the Kavango that if a traditional healer dies and no one in the family takes over their work, he/she will select one of the family members and will appear to them via dreams, and tell that person to become a traditional healer. If the person does not follow the wishes of the ancestors then that person will become sick with an unspecified condition that cannot be treated by biomedicine and will have to seek help from a traditional healer. In most cases when an individual is about to 'inherit' a healing spirit - usually the person chosen or 'called' becomes ill and this may take the form of mental confusion (Chavunduka 1994, p. 82). A proper diagnosis by an experienced healer will reveal that the victim is troubled by an ancestral spirit wishing to confer its healing powers upon him/her. Subsequently a ritual ceremony is

²³ When I was doing my fieldwork I was regarded as a *kangangwegwena* (assistant healer) and I spent most of my time with other assistant healers and I did carry out most the jobs as assigned by the *nganga*.

held at which the spirit is honoured and accepted by the person who will now become a trainee healer (Chavunduka 1994, p. 63). Among the Zulu speakers in South Africa, for example, it is believed that if a healer was not identified by the *idlozi* (the spirit of someone who was a *sangoma*) he/she will not have the ability to look into other people's lives and as such the person will not progress to become *isangoma* (diviner healer) (Gcabashe 2009, p. 20). However, in Kavango even if the person was not chosen by the ancestors (s)he can still move from *kangangwena* to *nganga* and ultimately *nkurungunganga*.

According to Karim et al (1994, p. 10) the work of the *kangangwena* or novice apprentice, is to act as messenger, herb gatherer and general helper to his/her master/teacher, accompanying him/her on his/her excursions as medicine-bearer. By doing so (s) he learns by observation and instruction (Chavunduka 1994, p. 48). Hence, the *kangangwena* has to learn to identify and name the relevant herbs, plants, animals, insects and birds which are used as part of the healing process as the first healer explained above. In addition the *kangangwena* is also required to hold the *katemba* for the *nganga* or *nkurunganga* during the diagnostic process. Later (s)he has to learn how to mix the various ingredients of plants and prepare a mixture of *mutondo* (medicine). In addition the *kangangwena* assists in the administration of medicines and is allowed to treat some sick persons by acting on the instructions of the *nganga* or *nkurunganga*s. After a few more years, the *kangangwena* is introduced to the management of progressively more severe illnesses and problems. Thereafter he may begin to treat sick persons on his/her own.

However, sometimes people living in the homestead of a *nganga* are used as *kangangwena* because some of the *nganga* and *nkurunganga* cannot administer the medication to the sick person themselves. This is because during their initiation ritual of becoming a *nganga* they have sacrificed²⁴ a person to strengthen their powers (Mbambo 2002, p. 152). It is believed that *ngangas* who has performed this ritual cannot administer the medication themselves to the sick persons; otherwise the persons receiving the medicine will die. Thus, the *kangangwena* has to assume this role. In cases where such healers do not have *kangangwena* they resort to using their spouses to administer the medication, or their own children, who then become *kangangwena* by default if not by choice.

²⁴ This practice is known as *kupitita*

One such case is the nephew of a famous deceased *nkurunganga* Kamangu. His nephew now works as a *Nganga* but he did not have any interest in traditional medicine as a young boy. Nevertheless his uncle used to send him around to collect plant, mineral and/or animal substances for medicine and to administer the medicine to the sick persons. After the death of his uncle he became a policeman and he is now retired from government and works as a *nganga*. He claimed to have the *katemba* (divination device) of his uncle which he showed to me. Yet many people believe that *nkurunganga* Kamangu's *katemba* is with Dr Maria Fisch²⁵: she was doing research on traditional healers with Kamangu at the time.

While there is no standard duration of studying traditional medicine in Kavango in many cases it takes not less than five years. For example, one of the five *kangangwena* working for the *nkurunganga* in the third narrative above said that he has been with him as a *kangangwena* since 2001, thus, more than 13 years. During my stay with the *nkurungunganga* I found his *kangangwena* very knowledgeable. He actually does everything that a *nganga* can do. I asked him if he was interested in becoming a *nganga*, and he replied that as long as the old man (his mentor) was alive he was happy to work as a *kangangwena*. As such the period of apprenticeship is not delineated since the training is informal. However - like the two healers in the case studies have shown - it is imperative to have a ritual ceremony when one moves from being a *kangangwena* to the *nganga*.

4.4.2 *Nganga* (General traditional healer)

Once a person has attached him or herself to a *nganga* or *nkurunganga* (s) he could become a *nganga*. Thus, a *nganga* can be defined as a person who has undergone intensive training as *kangangwena* on the use of indigenous medicine (plants, animals, insects, birds, snakes among others) and has mastered the skill and familiarity based on the prevailing social and cultural knowledge, attitudes and beliefs regarding physical, mental and social well-being, and the causation of illness and disability in the community. After the *kangangwena* has met all the

²⁵ Maria Fisch, is a medical doctor and amateur anthropologist, now retired, she has published about Kavango history during her time as a state ethnographer (Akuupa 2011, p.89). Her publications are written in German and as such, I could not access them.

requirements and mastered the skills and knowledge of medicinal plants and has treated sick persons under the supervision of a *Nganga* he/she can move to the next level of becoming a full *nganga*. Among the Kavango a ceremony is usually required before the person can start practicing as a *nganga* on his/her own, as in the case of the first healer above.

During the ceremony the community members who are interested can attend. The initiation ceremony of a traditional healer usually takes place at night at the homestead of the *nkurunganga*. The community members do not just come to witness: they will participate in the ceremony by clapping hands, singing and dancing while feasting- usually a cow will be slaughtered for the ceremony. Beating of the drums and dancing is believed to ‘wake up the spirit’ of the ancestors which can ‘lift up’ the consciousness of the *kangangwena*.

The *kangangwene* will be covered with a blanket and sit with a heated pot full of medicinal plants. He/she has to inhale the steam coming from the pot. This process is known as *kufuka* and needs to be performed by the *nganga* or *nkurunganga*. Before sunrise - when the dancing is energetic and becomes intense - the *kangagwenana* will have to swallow a substance locally known as *ndonondo twalinongo* and *mutehenena*²⁶, together with the raw heart of slaughtered chickens and a cow: the process is called *ndondera*. This is the occasion on which the genealogy of the healer and *kangangwena* is recited, and where the identity of the *nganga* is declared to others in attendance. In addition, the *nganga* will put some eye drops into the eyes of the *kangangwena* and will also make some incisions on the side of the head²⁷, as well as on the chest. Lastly, in the presence of the audience, the *kangangwena* will be given his/her own *katemba*, the diagnostic tool. Thereafter that person is ‘certified’ as a *nganga* who can practise on his/her own. While practising, the *nganga* may develop an interest in, and become a specialist in a particular field, for example the treatment of mental disorders or snakebites. Women healers often specialize in the treatment of children and women’s illnesses related to reproductive health e.g. abnormal menstruation, infertility, genital warts and hemorrhoid among other.

²⁶ Ritual medicinal cocktail

²⁷ Temporal lobe area.

4.4.3 *Nkurunganga* (Expert Traditional Healer)

A *nkurunganga* (Expert Traditional Healer) is a *nganga* who has been ‘qualified’ through the ceremony described above and has visited more than one traditional healer. The visits to other traditional healers are done secretly and usually involve performing dangerous rituals to enhance the *nganga*’s spiritual powers. Most of the *nkurunganga* will, so I was informed, have to sacrifice a family member to enhance the healer’s power²⁸. As indicated above, the ritual of sacrifice boosts the powers of a traditional healer and is known as *kupitita*. It is believed that a person who has been sacrificed will be used in the *katemba* to diagnose illness, especially witchcraft. Mbambo (2002, p .193) noted that when a *nganga* goes through the ritual of *kupitita* (s)he is ‘cooked’ (*kupya*) and moves from being an ordinary *nganga* to a combination of a *nganga* and a witch (*urodi*). Usually at this stage a *nganga* will have more than one *katemba*, which they will acquire in secret from other *nkurungangas*. An expert traditional healer can manage and treat all sorts of illnesses and usually he/she is also able to diagnose and treat witchcraft. (S)he is able to communicate with the spirits when in a state of possession and can act as an intermediary between the natural/spiritual world and the human/social world. *Nkurunganga* (expert traditional healer) mainly engage in some form of divination as part of healing within a supernatural context through culturally accepted mediumship with the ancestral spirits (Karim et al 1994:7).

Nkurunganga differ from each other in the methods they use in the diagnostic process. While the majority carry out diagnosis while in a state of possession (Chavunduka 1994, p. 72), others may become possessed while also casting the *katemba*: as in the case of Kavango healers. Unlike the *katemba* (divination) device of the *nganga* (general healer) - which usually contains the bones of animals or birds - that of the *nkurunganga* (Expert traditional healer) contains human bones.

Nkurunganga (expert traditional healers) are able to inform their clients of the reason for their visit and the social cause of their illness without having been told anything. Once a certain spirit

²⁸ An article in the Namibian in 2005, for instance, refers to a Police search for the body of a Kavango woman. A man was arrested on suspicion that he used parts of it in so-called *muti* rituals.
<http://www.namibian.com.na/print.php?id=12862&type=>

has been identified as the cause of an illness or misfortune, *nkurunganga* (expert traditional healers) will advise on the procedure necessary to propitiate the spirit, and they may also prescribe a herbal remedy to cure the physical malaise itself. In the next section below I am going to discuss the diagnostic process of mental illness by the traditional healers.

4.5 Diagnostic process of mental illness in Kavango regions

A traditional healer's diagnosis is both an art and a method of seeking to discover the origins of the illness (Truter 2007, p. 28). Hence, the diagnostic process not only seeks answers to the question of how the illness originated (immediate causes), but who or what caused the illness (efficient cause), and why it has affected this particular person at this point in time (ultimate cause) (Truter (2007, p. 58). In Kavango the diagnostic process is locally known as *kuyanikita*: it takes place at the healer's homestead under a tree or a veranda. During *kuyanikita* the traditional healer communicates with ancestors and the family members of the afflicted person to determine the illness, causes of the illness and the therapeutic actions that need to be taken. The *vanganga* (traditional healers) believe that for their medication to work they have to go through the ancestors (*vadimu*) and the *vadimu* will seek powers from *Karunga/Nyambi* (God). In this regard, the ancestors are believed to have a closer relationship with God since they have seen God and serve as mediators between the living and God. The God referred to here is not different from the God which Christians believe in. When I asked the traditional healers about the God they believe in they told me that there is only one God.

I observed that *muveri* (the sick person) and the family members were always received warmly by the *tungangwena*²⁹ (junior traditional healers) who seated them before the *nganga* (traditional healers) arrived. There is no consistency in terms of handling the *muveri* (sick person) or the manner in which questions are posed. In other words the diagnostic process (*kuyanikita*) is not standard. Each *muveri* was handled and treated differently. However, what was striking is that the *vangangas'* (traditional healers) consultations were holistic in nature and focused on the entire social context of the *muveri's* (sick person) illness. In this regard, the *kuyanikita* (diagnosis process) consisted of the following methods;

²⁹ *Kangangwena* singular and *tungangwena* plural.

- i. Observation (noting physical symptoms): for a mentally ill person traditional healers looked for physical symptoms such as salivation, dry mouth, ulcers, lacerations, bleeding, wounds, whether the eyes were bloodshot. They also focused on behavioural symptoms, e.g. aggressive behaviour or withdrawal among others. These symptoms were common among mentally ill persons and healers looked for these for various reasons. For example aggressive *muveri* (sick persons) were most likely to cause injuries to themselves. Healers were alert to this and provided treatment for wounds, lacerations etc. Secondly, some of the *mutondo* (medicine) that were used by the healers had some side effect e.g. salivation or dry mouth. Thus such symptoms were seen by the healers as an indication that the sick person might have been to other healers. Healers associated withdrawal symptoms e.g sadness with the *Nyambi* illness. Severely red/bloodshot eyes were seen as indicative of *Kasenge* and *Ndjangura* illnesses (see chapter five). To a certain extent physical symptoms informed traditional healers' diagnoses as well in their prescriptions of *mutodo* (medicine).
- ii. Profile of the *muveri* (sick person): traditional healers asked about previous illnesses, if the person was seen by another traditional healer or was taken to the hospital, current medications which the person is taking, and clan affiliation, to arrive at the nosology of the illness. Some of the traditional healers, especially the *nkurunganga* (senior traditional healers), did not build up a 'profile' of the sufferer, but claimed to see everything in the *katemba*. They would, instead 'reveal' the 'profile' of the *muveri* (sick person) to family members in attendance. Nonetheless, at times the 'profile' of the *muveri* was passed on to the senior traditional healers by their *tungangwena* (junior traditional healers) - who meet the family prior to the consultation. The *vanganga* (traditional healers) spent a lot of time with the *muveri* (sick person) and his/her family in order to establish the proper family history of the *muveri* (sick person) - which is linked to their final diagnosis via the *katemba* (divination device).
- iii. Divination through the *katemba*: is the foremost form of diagnosis among the *vanganga* in Kavango. Truter (2007, p. 58) explained that the main purpose of divination is to identify the cause of the illness and determine ways on how to remove, e.g. sorcery or to seek the ancestors' forgiveness through sacrifices and rituals to appease their anger or

by prescription of certain medication. Peek (2013, p. 2) defined divination as a process deriving from an extensive body of knowledge. He noted that although divining processes are diverse, all follow set routines by which otherwise inaccessible information is obtained. He explained that traditional healers make use of different devices from a simple sliding object to the myriad symbolic items shaken in diviners' baskets. Peek (ibid) further explained that sometimes the diviner's body becomes the vehicle of communication through spirit possession based on mechanisms that reveal answers. Other systems require the diviner to interpret cryptic metaphoric messages. The final diagnosis and plan for action are rendered collectively by the diviner and the client (Peek 2013, p. 2). In Kavango the *vanganga* (traditional healers) acquire their first *katemba* (divination device) during their initiation period and may accumulate more *katembas* later in life as they gain more experience in traditional healing. There were a number of *katembas* (divination devices) which were used by the traditional healers. The common ones are (i) *katemba kaliguni* (ground shell of monkey orange). (ii) *katemba kamupini* (handle of traditional axe) and (iii) *katemba ka ruvinga rwangonge* (cattle horn). I will discuss them in more detail below.

4.6 *Katemba kaliguni* (ground shell of Monkey orange).

This *katemba* is also known as *kandambo kamushumpuko watanto madu na shiri* (kandambo³⁰ who separates lies from the truth). The traditional healers use this type of *katemba* by turning from side to side and in the process communicate with the ancestors to determine the diagnosis and therapeutic actions that need to be taken. The *kuyanikita* process takes place in full view of family members (see figure 2 below). The healer will take the *katemba* and rub it against his body before placing it on a dry, treated skin of a wild animal. Mukoya explained that by rubbing the *katemba* against the chest it creates a power relation between the *nganga*, the *katemba* and the ancestor. Thereafter the *nganga* (healer) takes sand and throws it on the *katemba*: a symbolic welcoming of the people who have come to consult the *nganga*. A number of questions are posed by the *nganga* to the *katemba* while turning it from side to side.

³⁰ Kandambo is the name of a female healer who is believed to have first used this type of *katemba* and it has been named after her.

During a consultation (figure 2) the healer said:

kandambo kamushupuko you are the one who separate the truth from lies, tell us in honour of our ancestors. We saw the sun rise this morning! Will we see sunset today? (His hand came to a standstill) Are you sure we will see sunset today? Ewa (OK). Who is a *muveri* (sick person) here? While pointing at the people who came to consult, ‘is it this one, or that one’ then the *nganga* stopped at one point while pointing at the *muveri*.

The *katemba* came to a standstill again. The *nganga* continued to asked more questions in an attempt to determine the origin of the illness and the treatment to be given. But the logic is that once the question is posed, the *katemba* turns: if it does not stop, then another question will be asked. For example, the healer will ask the *katemba*: “Is the person suffering from *nyambi? kasenge, ndjangura?*” A diagnosis will only be made once the *katemba* comes to a standstill. This is followed by the causes of the illness and lastly the therapeutic action that needs to be taken.



Figure 2 *nkurunganga* using the *katemba kalingu* in view of family members



Figure 3 Michael Shirungu learning how to use the *katemba* under the auspices of George Mukoya a senior traditional healer.



Figure 4 George mukoya a *nkurunganga* (senior traditional healer) demonstrating the use of *katemba kalingu* at his homestead.

4.7 *Katemba kamupini* (handle of traditional axe)

This is another type of *katemba* and is mainly used by the junior traditional healers (JTH) by moving it up and down to determine the causes of the illness and therapy needed. It works in the same manner as the *Katemba* of cattle horn but it is more ‘friendly’. Using it does not involve a lot of risks and does not cause injuries to the healer or any other person. It diagnoses the illness by providing answers to the healer.

4.8 *Katamba ka ruvinga rwangonge* (Katamba of cattle horn)

The *Katamba* of cattle horn requires two assistant traditional healers (ATH) to hold it during the diagnosis process as shown in Figure 3 above. This type of *katamba* moves up and down as the *nganga* poses the questions about the illness. In response to what the healer is asking it, this *katamba* writes on the ground while in the hands of the two assistant traditional healers. For example, the healer asks the *katamba* how much people should pay.³¹ It writes the payment, demanded by the ancestors, in the sand: an amount of money, a number of goats, cattle or chickens. Thus, the *katamba* determines the diagnosis, therapeutic actions that needs to be taken, as well as the consultation fee. In most cases it is used by the senior traditional healers. This type of *katamba* is normally utilised by the traditional healers to diagnose witchcraft related illnesses. This *katamba* is very dangerous as it sometimes injures a *murodi* (witch) especially if he/she denies the allegations by the healer. At times it can even hurt the traditional healer if the *katamba* payment demands are not met and he continues with the diagnostic process.



Figure 5 Michael shirungu and George mukoya (nganga) holding *Katamba* of cattle horn.

³¹ Usually people are required to pay the consultation fees upfront, however if they do not have the money they are allowed to make the payment at a later stage. Some traditional healer's only request payments if the *muveri* (Sick person) recovered from the illness.



Figure 6 George mukoya a nkurunganga (senior traditional healer) demonstrating the use of katemba karuvinga.

In Namibia, on legal grounds, it is not permitted to name a person as a witch. This is in line with the Witchcraft Suppression Act of 1933 which made it an offence for a person: to exercise supernatural powers, to impute the cause of certain occurrences to another person; and to provide for incidental matters. Regardless of the witchcraft Suppression Act, in Kavango traditional healers can get permission from the chief (*Hompa*) to diagnose witchcraft. Diagnosing of witchcraft is a public event and it should be announced in advance so that community members can attend the event.

Nowadays a traditional healer can indicate to family members of a *muveri* that his/her illness is caused by witchcraft without mentioning a specific person. If a witch is named, the family members need to pay lots of money to the *nganga* – who takes a risk by identifying and naming a person as such. Apart from its possible legal implications, identifying a person as a witch also results in family conflict, disruption of social relations and loosening of clan affinity. This is because witchcraft is mostly suspected within kinship relations.

As seen above, traditional healers in Kavango are relevant to the local community: however, the utilisation of traditional healers and their inclusion in the official health care system is a complex process. Yet almost no progress has been made in Namibia in this regard. Attempts to train and utilise healers abound in developing countries, notably with regard to midwifery

(Freeman and Motsei 1992, p. 188). In the next section I am going to scrutinize the legal status of traditional healers in Namibia and Kavango in particular.

4.9 The legal status of traditional healers

After Namibia gained independence the government has made numerous attempts to coordinate traditional healers and community use of traditional medicine (Lumpkin 1993, p. 8). At national level talks about traditional healers started after the establishment of the Namibia Eagle Traditional Healers Association (NETHA) under the Ministry of Health and Social Services on 7 October 1990. The dialogue was aimed at organizing and registering all traditional healers in Namibia. Lumpkin (1993, p. 9) outlined the objectives of NETHA are as threefold:

- i. To provide a therapeutic community of traditional healers offering supportive environmental health programmes to the physically ill, the mentally and emotionally disturbed, and the developmentally handicapped in Namibia.
- ii. To provide extension management and consultancy services for traditional healers.
- iii. To be a link between the government, NGOs, and traditional healers.

The above objectives were based on a traditional healing philosophy that included the utilisation of traditional medicine or traditional practices, maintaining or restoring the physical or mental health or functions of a person; diagnosing, treating or preventing a physical or mental illness in a person; and rehabilitating a person to enable the person to resume normal functioning within his or her family or the community; or preparing a person for puberty, adulthood, pregnancy, childbirth or death, either physical or emotional.

The following exclusions applied:

- i. The performance of professional activities or functions of a person registered under the Allied Health Professions Act, 2004 (Act No. 7 of 2004), the Medical and Dental Act, 2004 (Act No. 10 of 2004), the Nursing Act, 2004 (Act No. 8 of 2004), the Pharmacy Act, 2004 (Act No. 9 of 2004) or the Social Work and Psychology Act, 2004 (Act No. 6 of 2004), or any other activity not based on a traditional healing philosophy; and

- ii. Any act or other activity prohibited by or under the Witchcraft Suppression Proclamation, 1933.

During my fieldwork traditional healers spontaneously presented the Namibia Eagle Traditional Healers Association (NETHA) certificate to me (certificate included in appendix). Most of the traditional healers got the certificate in the mid-1990s through the Ministry of Health and Social Services. Although they did not know how NETHA was supposed to operate they were happy to have evidence of recognition for their work as healers, assuming that they had paid once-off membership fees. In fact the work of organisation work had long since ceased (or been put on hold). Yet the certificate is still valued by individual healers. Mashango, a female traditional healer explained³².

I am actually happy to be recognised as a healer and I have a paper to show for it. The organisation does not even ask us to pay annual fees like our own local traditional authority. I even ask myself why I should pay for my gift from God as if I am doing a business. All I do is to help the needy and I do not ask for any payment.

Most of the traditional healers in Kavango were unaware that NETHA was not operational anymore and had never achieved its objectives. In 1994, the Namibian Parliament passed an act requiring all health workers, including traditional medicine practitioners, to become legally registered and in March 1996 the Traditional Health Council of Namibia was established under the Allied Health Professions Act of 1993, act no. 20 of 1993 (Lebeau 1998 and Lumpkin 1993). The council was mandated to register traditional healers in Namibia and instill professionalism in their practice (Chinsebu 2015, p. 14). However, in 2004, the Allied Health Services Professions Act of 1993 was replaced by the Allied Health Professions Act (Act No. 7 of 2004). The Traditional Health Council was subsequently dissolved. This was the end of NETHA and talks concerning the regulation of traditional healers and their medicines came to a halt, leaving many Namibian traditional healers in a legal quagmire and organizational lacuna (Chinsebu 2015, p. 15). In other words this left many traditional healers without an organization that is legally recognized by the state to regulate, support or advise them: e.g. in

³² The picture of Mashango and the author is attached as an appendix six.

cases of lawsuits.

In the absence of official recognition, traditional healers in Kavango and Namibia currently operate without licenses. Some work under the auspices of the Traditional Authority such the headman/woman or chief of the five Kavango traditional authorities namely; *Mbushushu, Gciriku, Shambyu, Mbuza and Kwangali*³³. Others join under unofficial organizations like the Kavango Traditional Healers Association. Strictly speaking there is no Traditional Healer's Association in Kavango which is recognised by any of the five traditional authorities or the government.

There were a number of reasons why the Traditional Health Council was disbanded by the Ministry of Health and Social Services. In the early 1990s HIV/AIDS was increasing alarmingly. Traditional healers were seen as a part of the problem since some of them claimed to have a cure for HIV/AIDS. This contradicted and undermined the Ministry of Health and Social Services' HIV-related policies and programs (Shirungu 2015, p. 40). In this regard, Chinsebu (2015, p. 15) outlined some of reasons for the abolishment of the traditional health council

- i. Charlatan traditional healers that claimed cures for HIV/AIDS.
- ii. Public outcry against traditional healers who encouraged sex with a minor or virgin as a cure for HIV/AIDS.
- iii. Lack of referral of HIV/AIDS patients to the hospital.
- iv. Potential friction with donors supporting conventional anti-retroviral treatment (ART) programmes, and
- v. Fears of non-compliance with conventional ART programmes. Following the demise of the Traditional Health Council, the Ministry of Health and Social Services and the World Health Organization jointly undertook a study - entitled Scientific Evaluation, Standardization, and Regulation of Traditional Medical Practices in Namibia - in 1997. The findings of this study guided the development of the 1998 draft Traditional Healers Bill which was tabled in the national Parliament last year (2015) by the former Minister of Health and Social Service, Richard Kamwi. The bill has six main objectives

³³ See chapter one on Kavango local administrations under the five traditional authorities.

summarized as follows:

- i. To provide for the establishment, constitution, powers and functions of the Traditional Health Practitioners Council of Namibia;
- ii. To regulate the registration of traditional health practitioners and the practice of traditional healing;
- iii. To prohibit the practicing of traditional healing without being registered;
- iv. To provide for different categories of traditional healing and different requirements for Namibian citizens and persons who are not Namibian citizens;
- v. To provide for the establishment of the Interim Traditional Health Practitioners Council of Namibia; and
- vi. To provide for incidental matters.

The 72-page traditional Healers Bill was not adopted by Parliament: pending issues around registration, regulation, issuing of sick and death certificates, and coverage by medical aid among other matters. After a heated debate it was proposed that the Bill be referred to a relevant Parliamentary Committee - which must consist of members who are well versed in the subject to carry out proper consultations - before it can be tabled again in Parliament (new era 2014). Up to till now the government has been silent on the Traditional Healers Bill and the new Minister of Health and Social Services, Benard Haufiku, a medical doctor, has not referred to it to date. In legal terms any person who practices medicine without a license can potentially be prosecuted.

At the same time Dauskardt (1990, p. 353) remarks, that if the state cannot regulate traditional practice or include it in the official health care programmes, it deprives itself of an important health care resource. In Namibia traditional healers who currently continue to provide primary health care to the local people are not recognised by the authorities in terms of policy, regulation and integration in the mainstream healthcare structures: it remains a contentious issue (Meincke 2015, p. 45). This is despite The World Health Organisation's (WHO) call for the integration of traditional medicine into Primary Health Care (PHC) systems since the late 1970s.

4.10 Conclusion

In this chapter I discussed various categories of traditional healers in Kavango, their diagnostic process as well as their current lack of legal status. Traditional healers continue to play a vital role in the community by providing health care at the local level, especially primary health care. I argued that the current classification of traditional healers into the broader categories of herbalist, diviner, and medium-diviner makes it difficult to distinguish between them. In this regard, traditional healers' roles, methods of diagnosis and treatment overlap considerably. Hence, I proposed three new categories, namely *Kangangwena* (assistant traditional healer), *Nganga* (general traditional healer) and *Nkurunganga* (expert traditional healer) as a better way of understanding the traditional healer in Kavango. This can help to determine the level of training and knowledge but also the area of speciality. I also argued that, while traditional healers play a vital role in the health care of the individuals, families and the community, up to the present traditional healing in Namibia and Kavango remains largely unregulated. To utilise healers as part of the health care team could meet needs currently not met by the official health care system, and help to bridge the cultural gap in the conceptual appreciation of health and illness.

CHAPTER FIVE

5 SOCIAL AND CULTURAL CONSTRUCTION OF MENTAL ILLNESS FROM THE (VANGANGA) TRADITIONAL HEALER'S PERSPECTIVE

5.1 INTRODUCTION

This chapter discusses the social and cultural construction of mental illness in Kavango. I will deliberate on local notions (expression of belief patterns, thoughts and ideas, or meanings) of mental illness based on different local names/categories that the *vanganga* use to construct mental illness. What I argue is this: not only the understandings of mental illness, but also of the world in general forms the basis for the shared assumptions of healers about reality (Berger and Luckmann 1966). I view cultural constructions of mental illness as common sense knowledge and application of traditional healing on a daily basis by traditional healers, as well as how they view, relate to and interpret mental illness in the social context. Swartz (1998, p. 16) warned that thinking culturally is not about applying cultural labels to what we see, but rather to reflect in the face of what the world offers us.

I am going to show that while traditional healers see mental illness as an affliction which affects the sick person's head/brain/mind, they also make sense of it as a social and cultural problem which causes disruption in the family and the community, brought about by angry (*vadimu*) ancestors, or (*varodi*) witches. Accordingly, therapeutic action aims not only to treat, and preferably cure, the sufferers, but also to restore the social order disrupted by the angry ancestors or witches. In this regard, the *vanganga* (traditional healers) restore the social order at family level through the *kutjamba* ritual ceremony, and at the community level, through the *kuvetera ngoma* (drum ritual ceremony). I will focus in particular on the three common mental disorders (CMD) (1) *Nyambi illness* (2) *Kasenge illness* and (3) *Ndjangura illness* which were identified during the study. While these three common mentally related illnesses are unique and specific among the Kavango people - and based in their local cultural setting - (DSMIV, 1994; Littlewood & Lipsedge, 1989), they are not discrete categories.

Thus I put more emphasis on the context and meaning, rather than signs and symptoms. I will furthermore argue that these mental illness categories are not fixed or objective, but differ in terms of manifestation and the basic underlying assumptions influencing issues of explanation and treatment (Long and Zietkiewicz 1997, p. 7). I argue that while traditional healers view these local notions of mental illness as static, in reality they are active concepts constituted by culturally and socially relative categories, the precise boundaries and meanings of which vary over time (Foucault, 1967). In this regard, it became evident in the study that traditional healers' expressions of belief patterns, thoughts and ideas of the three local mentally related illnesses are not inert since the perceived signs and symptoms differed and overlapped and they treated the same condition in different ways. Before I discuss the common mental illnesses let me first present traditional healers' accounts of illness (*uvera*).

5.2 Traditional healers' conceptualization of *uvera* (illness)

It is imperative to understand the local views of illness, since explanations of it are based on the constructs of social situations as found in local notions, or theories. Traditional healers gave a range of explanations for *uvera* (illness) drawing on their past experiences and observations as well as knowledge orally handed down from generation to generation (White, 2015, p. 7). There is no local terminology which is directly equivalent to illness but the local term *uvera* used by the traditional healers comes very close to it. *Uvera* can be loosely translated to mean illness, sickness or even a disease. Traditional healers' theories about illness can be grouped into four categories/domains (1) *uvera wakarungu* (illness which are God related, or natural illness), (2) *uvera wavadimu* (illness causes by the ancestors), (3) *uvera wavarodi* (illness caused by the witches) and (4) *uvera washidira* (illness caused by breaking taboos). In this regard, different traditional healers defined *uvera*/illness as follows:

- Shamwaka ... *uvera* is when a person is not feeling well due to pain in the body, head, heart, bones or skin irritation. Sometimes the person may have *uvera* (illness) due to bad spirits (angry ancestors) and witches.
- Mukoya.....*uvera* is when a person cannot carry out his/her normal routine and devote most the time in bed. Such a person will feel warm or cold, headache, nausea and vomiting, diarrhoea etc. Then such a person is a *muveri* (a sick person).

- Nawandambu. *uvera* is in the body of a person, sometimes it can be visible as in the case of body rashes, red eyes, an abscess or the person may feel tired. At times *uvera* (illness) is not visible but the person might have low appetite, lose weight or some might behave abnormally, such a person is ill.
- Shashipapo...*uvera* is when a person has pain in the body, or when one part of the body cannot function well, and that person needs help to restore the physically and spiritually disruption.
- Hausiku... *uvera* is when a person is not feeling well in the body or the head. It can be caused by the ancestors, witches or at times due to a change in the weather, or by God himself/herself.

From the above it is apparent that traditional healers' accounts of *uvera* (illness) go beyond the physiological and psychological/emotional disruption of the body of the *muveri* (sick person) to include the disruption of social order of the family and community by the ancestors or by witchcraft. White (2015 p. 7) noted that traditional healers in many African countries associate illness with attacks of evil or bad spirits. It is believed that when the ancestors are not treated well (neglected or forgotten by their relatives) they could punish people with illness and their anger is usually appeased through ritual performances (White, 2015, p. 7).

Traditional healers in Kavango also viewed illness as something which could be caused by witchcraft, i.e. that people with evil powers could cause other people - whom they saw as their enemies or disrespectful to them - to become sick. A person considered to be ill/sick is called a *muveri* (a sick person). However, it must be noted that traditional healer accounts of *uvera* (illness) not only refer to what the sick person feels, it also includes what the family members or community members perceive, live with and how they respond to symptoms and the disability caused by the illness (see Kleinman 1988, p. 4).

At the same time traditional healers derive their world view of *uvera* (illness) based on the perceived origin and causes of the illness, i.e its aetiology. For example traditional healers perceive illness such as malaria, or a moderate cough caused by a cold and/or flu as natural, or God related illness. Such illnesses were normally treated with medicinal plants or referred to the

hospital e.g, malaria. However, if a *muveri*³⁴ (a sick person) fails to respond to the initial treatment then traditional healers might look at the possibility of other causes such as the ancestors, witchcraft or the breaching of a taboo, which normally requires ritual cleansing.

I hope this brief background of *uvera* gives some insight into how the traditional healer's perspective on mental illness is different from disease and sickness, although they may overlap. Kleinman (1988, p. 5) explained that disease is what biomedical practitioners diagnose: in terms of theories of disorders based on their professional training and understanding, in a particular form of practice. Hence, the biomedical practitioner reconfigures and interprets the patient's (and family's) illness problems within a particular nosology as a disease, in order to create a diagnostic entity (ibid). Sickness in the biomedical context is the understanding of the disorder across the population in relation to macro-social aspects such as economic, political and institutional forces (Kleinman 1988, p. 5). Against this background I contrast the construction of mental illness by the *vanganga* (traditional healers).

5.3 The construction of mental illness by the *vanganga*

I pointed out in chapter 1 that it is difficult to study local concepts of mental illnesses given that local knowledge is continually being reproduced and evolving, and is often somewhat idiosyncratic and context dependent (Ventevogel et al 2013, p. 2). In addition local knowledge may also vary due to historical changes, as well as shifting geographical boundaries. This is also the case in Kavango where some people live south of the Kavango River, with the majority of people on the Namibian side. Others live north of the river, on the Angolan side. By presenting traditional healers' constructions of local notions of mental illness I do not view their aetiologies in a rigid way, given the changing nature of our social world and the efforts of individuals to adapt to these changes, I thus view these local notions as an ongoing process or work in progress.

The *vanganga* in Kavango construct mental illness based on their diagnostic methods, operating from the point of view of traditional healing systems and using spiritual forces as a mode of

³⁴ *muveri* (singular) and *vaveri* (plural)

communication with the ancestors via the *katemba* (divination device) to determine the cause of, and to identify, the illness. Within these systems, mental illness is frequently seen as a sign that the family has deviated from cultural norms, as a form of harm instigated by a jealous third party or as a physical problem (Teuton et al 2007, p. 1262). In this regard, mental illness is locally ascribed to various causes, such as nature (i.e. physiological, as something that runs in a family, as a result of injuries, substance abuse etc.), the angry (*vadimu*) ancestors and witchcraft (*varodi*). Therefore, while traditional healers view mental illness as a physical ailment that causes disruption of mind/head/brain they also see it is as a possible result of social deviance - which can anger the ancestor enough to impose the illness on an individual, or as a result of witchcraft by a jealous third party. Unlike most studies in which mental illness has been constituted as highly individual, personal and private (Swartz 1996), the *vanganga's* explanation of mental illness includes components of social and psychological approaches which provide meaning for the mentally ill persons and their families (Teuton et al 2007, p. 1262).

To bring out both the cultural and social meaning of mental illness I will scrutinize the traditional healer's account of local notions of mental illness, based on ethnographic data collected during my fieldwork period. This is not to argue that I view the social and cultural construction of mental illness as "independent variables" in understanding mental illness in Kavango. Rather, I try to unpack the local notions of mental illness as per the conceptual, culturally informed way of thinking about mental disorders in the social context of perceived causes, diagnosis, treatment methods, and ritual ceremonies which are used in the interpretation of social behaviour of people who are thought to have mental problems. The focus is on the three common mental related 'disorders' which were identified during the ethnographic study namely; (1) *Nyambi* illness (2) *Kasenge* illness and (3) *ndjangura*. These local categories are as per table 2 below.

Table 2 Traditional healer's explanatory model of mental illness in Kavango regions

Indigenous name used by the <i>Vanganga</i>	Perceived causes	Symptoms
<p><i>Nyambi wamughutara</i> (Madness in which the <i>muveri</i> (sick person) always wants to be on high ground)</p>	<p>Natural as an illness which affect people from the Hawk clan, Environment including a change in the weather or the climate, in relation to their values, beliefs Seasonal, it mostly affects people during harvesting. Congenital</p>	<p>Running around Hyperactive, saying things which do not make sense Hearing of strange fun voices Removing of clothes and nakedness in public</p>
<p><i>Nyambi yoshikorwa</i> Another type of <i>nyambi</i> which is also common and seen as natural or a God related type of mental illness which can affect everyone in the community at any given time.</p>	<p>Natural,</p>	<p>Looking upwards all the time Hearing strange voices saying things which do not make sense, eating faeces,</p>
<p><i>Nyambi ghomathimu</i> This is believed to be caused by ancestors and is associated to witchcraft.</p>	<p>Bad spirit Ancestors curse</p>	<p>Running around hallucination, aggression feeling fearful and persecuted Removing clothes moving naked in public Talking incessantly Eating dirt and faeces</p>

		Bad hygiene
<i>Kasenge</i>	Witchcraft	<p>Fearful of red colours</p> <p>Red eyes</p> <p>Crying without stop</p> <p>withdrawal</p> <p>Inability to concentrate</p> <p>Saying things which does not make sense, a loss of touch with reality, being</p> <p>Hyperactive and talkative in the later stage</p> <p>Running wildly</p> <p>Assaulting people</p>
<i>Ndjangura</i>	<p>Supernatural forces as a causal factor.</p> <ul style="list-style-type: none"> ▶ Disturbed ancestral spirits ▶ Bewitched 	<p>Fearful of red colors</p> <p>scared of seeing certain individuals</p> <p>Isolation</p> <p>Sadness</p> <p>Red eyes.</p> <p>careless in dressing</p> <p>Talks irrationally</p> <p>Suffers auditory and visual hallucinations</p> <p>Walking aimlessly or naked</p>

These local notions in the above table by the traditional healers would be literally translated as madness: *kupurumuka* (*Vagciriku* and *Vasambyu*) *kurundumuka* (*Hambukushu*) and *kuzaruka* (*Rukwangali*) and a disruption of the mind/brain or head resulting in behavioural disturbances.

Among the defining features are interpersonal violence, chaotic behaviour (walking aimlessly or naked, talking nonsense, talking when alone, talking without stop, eating faeces and bad hygiene) indicating that a person is in some or other way abnormal/ insane, or mad. In addition bad spirits, angry ancestors or witchcraft are believed to cause mental illness: based on the conceptions of the relationship between the self and others (both the living and the dead). In this regard, it is believed that the spirits of the dead, as well as some human beings, are often at the root of a person's illness, death, and other misfortunes. The above table was generated based on the traditional healer's explanatory models. An explanatory model (EM) is defined by (Kleinman 1988, p. 4) as the: notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process. These models are linked to particular categories of illness and reveal labels and cultural idioms for expressing the experience of illness (see also Stein 2010. p. 284).

I link this model to local notions of mental illness based on traditional healers' views/perceptions and/or diagnoses of causes, patterns/ symptoms/ presentations of distress for mental illness in general and for specific conditions. Traditional healers saw these local notions as illness – not as disease or just as psychosocial conditions: their notion of illness is not the same as that of biomedicine or psychiatry, as illustrated above.

Therefore, traditional healers' therapeutic aims are to both treat the mental illness as well restore the social order disrupted by angry ancestors and witches, and to return the afflicted person and his/her family to good health, physical, social and spiritual equilibrium. Thus, traditional healers in Kavango take a holistic approach to illness and healing. It involves administration of medicinal plants and performing rituals based on their socio-cultural context.

The local notions of mental illness identified in this research are not set diagnostic categories with a specific set of symptoms, but have fluid boundaries and are applied pragmatically. For example, while *nyambi ghomathimu* may be associated with features of major depression, it is also a rather idiomatic expression to communicate that a person does not feel well and is overwhelmed by the tasks of life. Therefore, these local notions should not only be understood as a local syndrome, but also as an idiom of distress, and a culturally prescribed way of

communicating distress. An idiom of distress may be indicative of psychopathological states that undermine the well-being of a person, but may in other cases be seen as adaptive reactions to situations of distress, and thus ways of coping with it (Ventevogel et al 2013). Local aetiologies for the identified mental illness are set out below.

5.4 *Nyambi*

Nyambi is a type of mental illness that is very common among the Kavango people. Traditional healers said that the illness has been around for a long time. It is believed to be complex and can present with a range of symptoms (as shown in table 2). *Nyambi* illness is further subdivided into three types namely;

5.4.1 *Nyambi wamughutara*

Nyambi wamughurara is the the type of madness in which the *muveri* (sick person) always wants to be on high ground. Most of the *nyambi* sufferers are believed to prefer climbing onto a veranda (usually made of woods and reeds) locally known as *ghutara* hence, the name *nyambi ghomughura*. However, some of the *muveri* (sick persons) may climb a tree, building or any other structure as long as they are high and far from everyone because they see things that other people do not see and the hear voices that others do not hear. Traditional healers believe that the *muveri* (sick person) want to be high up because they see threatening things e.g. snakes, lions, or being chased by a ghost (*ghurumba*). While some traditional healers hold the view that the illness derives its name from the *muveri*'s love for heights, Weka (a senior traditional healer) argued that it is called *nyambi womughutara* because of the drum-healing ceremony, which always takes place under the *ghutara* (*veranda*). *Nyambi womughutara* sufferers are believed to be fearful of people with a light skin, or wearing clothes with red colours. In this regard, the red colour makes them more aggressive and they may attack a person wearing it.

Horgan (2015, p. 5) remarked that the “colour cure,” device was used by physicians in an asylum on Ward’s Island (Canada) in which mental patients were put in rooms dominated by

one of the primary colours. He explained that patients with acute mania were put in black rooms, patients with melancholia in red rooms, violent rooms for mild forms of insanity, blue and green rooms for the boisterous, and a white room for a recovering person who is practically well. He gave an example of a melancholic woman who, when shown a red room, raised her head instantly, and looked into the room. The ‘vibrations’ produced by this room had evidently been felt by her, while those of different colours had no effect. In this way the room was generally selected for the patient (Horgan (2015, p. 7). This type of treatment is known as the “colour therapy” or “chromotherapy,” which was used in the past as a treatment for mental disorders.

Ngubane (1977, p. 113) opined that colour plays an important role in symbolism related to ‘mystical’ illness. She argued that white, red and black are important colours: and red as the colour of sunset, also symbolize a transition illness. In Kavango traditional healers do not use colour therapy: however, they do isolate *nyambi womughutara* sufferers from red colours since it makes them more aggressive. Red is regarded by traditional healers in Kavango as a symbol of danger that should be avoided by the mentally ill at all times

I observed that most of the *muveri* (sick persons) that were classified as suffering from this condition were hyperactive and positioned themselves in a strange position and at times rolled on the ground. While in such a position the person would look around and talk to themselves as if they are having a conversation with someone. According to the healers, this type of *nyambi* is caused by nature, or is a God- related type of mental illness. In this regard, it is seen as an illness within the body or caused by the environment, which can affect any person. However, some of the healers associate the illness with the Hawk clan. For instance Nawandambi, a female traditional healer, said:

Nyambi Wamughutara is the illness of the *Vakandjandi* (Hawk) clan. In actual fact it is worse this time of the year, during the rainy session (*Lipemba*) when most of the crops ripen and are ready to be harvested. During this time we get a lot people suffering from *Nyambi Wamughutara* and they are all from the *Vakandjandi* (Hawk) clan.

Mbambo (2002, p. 106) briefly supported Nawandambi's claim as follows: *Nyambi* falls under the category of mental illness and people believe that it affects anyone who belongs to the *Vakandjandi* (Hawk) clan. It is one of the ritual illnesses that comes back every time people start to eat new crops, the *nyambi* sufferers need to be treated again before they eat it. Although Mbambo does not go into detail nor make any distinction between the different types of *nyambi* or mental illness in general, he raises two aspects which are crucial in understanding the *nyambi* illness relating to its causes. Throughout my interaction with the traditional healers there was a general understanding that *nyambi* only affected the hawk clan and secondly, that the *nyambi* was a seasonal type of mental illness which occurred, worsened or relapsed during the harvesting season. Those identified and classified as *nyambi* sufferers were cautioned not to eat any new crops until they had been cleansed by traditional healers. The new crops include *mahangu* (millet), maize, sugarcane, watermelon and local vegetables among others. It is expected that all the persons who were treated previously with *nyambi waghutara* should pay a courtesy visit to the healer before they ate new crops.

However, Shamwaka, a senior male traditional healer (STH) contested both Nawandambu's version and Mbambo's claim of the link of *nyambi wamughutara* to the *vakandjandi* (Hawk) clan, remarking as follows:

Nyambi wamughutara is not only confined to the *vakandjandi* (Hawk) clan but the illness can affect anyone regardless of which clan one belongs to. I have treated many people some came from as far as Owamboland³⁵ like that man, a teacher, whom you found here on your first visit. He was suffering from *nyambi wamughutara*, but he is not from the *vakandjandi* (Hawk) clan.

The treatment of this type of mental illness varies, as Shamwaka told me when I asked him about the treatment of sick persons who were under his care:

For the male *muveri* (sick person) under that tree I am giving him *kayanambo* (*Asparagus nelsii*) which is an important plant in the treatment of any type of *nyambi*. The *kayanambo*

³⁵ Ovamboland or Owamboland is situated in the northern Namibia and it is divided into five regions for political administration purposes. The five regions are now commonly referred to as "the North" but the term Ovamboland is still in use. More than half of the entire population lives here on just 6% of the Namibian territory.

(*Asparagus nelsii*) is responsible for removing bad spirits, other plants that I am using includes *mpeke* (*Ximenia Americana*), *mutengura* (*Bobgunnia madagascariensis*) and *mpumutji* (*Euclea divinorum*). I normally give it as a cocktail/mixture. *Mutengura* (*Bobgunnia madagascariensis*) and *mpumutji* (*Euclea divinorum*) make a person calm down and ultimately he/she will sleep.

For the severe mental illness like *Nyambi* the treatment takes about three to six months for the person to be well. Normally the treatment will be followed by the ritual drum ceremony under the *ghutara* (veranda), which I discuss in detail later.

5.4.2 *Nyambi yoshikorwa*

The above is another common subtype of *nyambi* which is regarded as a divine type of mental illness which can affect everyone in the community at any given time. The perceived or known symptoms include social withdrawal, antisocial behaviour, isolation and quietness/unwillingness to speak to people. It is believed that that the person might refuse to speak to people even for days on end. When he/she is asked a question or (has) been called by name such a person will not answer but instead will just gaze at the person and remain mute. In addition the person has low appetite and loses interest in normal household activities e.g. cooking, cleaning etc. *Nyambi yoshikorwa* sufferers are mostly regarded as harmless, but in a later stage of the illness some might sporadically become hyperactive and aggressive, or speak only to certain individuals, or to one particular person. People who are considered to be suffering from *nyambi yoshikorwa* are normally given the concoction from the leaves and roots of *mpindu* (*Ancylanthos rubiginosus*) and *muthimba* (*Dialium engleranum*) to drink. *Mpindu* (*Ancylanthos rubiginosus*) is believed to uplift the mood and get the person talking again, while *muthimba* (*Dialium engleranum*) is given to mimic the side effect of *mpindu* (*Ancylanthos rubiginosus*) which is believed to cause dryness in the mouth. This speaks to the ethno-pharmacological knowledge of the traditional healers to which I alluded in chapter 6, regarding the efficacy of their medicine.

Nyambi ghomutara-like conditions are also found in various African populations. For example

Ventevogel et al (2013, p. 12) in their paper entitled “Madness or sadness” gave an example of *ngeyec*, a type of mental illness among the Luo community in Kenya, with a description similar to the DSM-IV definition of depression. However, the defining feature cited by the Luo respondents was not its emotional aspect, but the existence of typical somatic symptoms, in particular pressure on the stomach and diarrhea (Ventevogel et al (2013, p. 12). Similarly, *Ibonge* in Burundi also resembles depression as a type of sadness resulting from multiple sufferings with symptoms such as deep sadness, isolation, lack of self-care, loss of mind, inability to work, feeling life is meaningless, not being pleased by anything and having difficulty in interacting with others (Ventevogel et al 2013 p. 12). Understanding local notions of mental illness is complex since the healers’ and the local perceptions of mental illness might not be easily visible to the researcher. As argued in chapter 3, mental illness is culturally defined, and varies markedly from culture to culture, society to society and from person to person - hence, people experience and respond to such illness differently.

5.4.3 *Nyambi ghomathimu*

Nyambi ghomathimu is mainly believed to be caused by angry ancestors (*vadimu*) and at times is associated with witchcraft (*varodi*). In this regard, it is believed that if a member of the clan is not well treated by other family members, the ancestors gets angry and impose an illness on the family member who is been mistreated. *Nyambi yomathimu* is characterised by severe anxiety and constant fear: the afflicted person sees strange things e.g. snakes or fire, and hears strange voices, especially at night. People who suffer from *nyambi ghomathimu* appear to be upset most of the time and their condition deteriorates during the night. Usually they will start screaming and at times appear to be confused. Traditional healers believe that this happens because ancestors visit them at night and bad spirits worsen the condition of the affected person every time the ancestors pay a visit. One must always be cautious when handling such a *muveri* (sick person) because they can be very aggressive and may cause harm to themselves or other.

Nkosi (2012, p. 96) explained that the ancestors are supernatural beings that were once human, who were once part of the family and are still considered to be part of the family in spirit via the kinahip lineage. He argued that many Africans describe them as those who connect

them with the creator or the ones who communicate on their behalf. The more they communicate with the ancestors, people believe, their ancestors bring some sort of fortune, prestige and continuity of their descent group, as strongly as the living (Nkosi 2012, p. 96). If there has been a communication breakdown (such as disobedience) it is believed that ancestors possess the ultimate power to punish people in the form of illness, bad luck and other misfortunes. Therefore, it becomes essential for the living to conduct rituals in honour of the dead.

The idea of ancestors causing mental illness was also observed by Honwana (1998) in Mozambique and Angola. In both countries people believe that mental illness is directly related to the anger of the spirits of the dead. She explained that in southern Mozambique these spirits are called *Mipfhukwa* -the spirits of the dead believed to have been killed unjustly, and who did not have a proper burial, attended by all the rituals aimed at placing them in their proper position in the world of the ancestors (Honwana 1998, p. 105). Thus, their souls are unsettled, they are spirits of bitterness, believed to have the capacity to afflict the living by causing mental illness and even the death of those who mistreated them in life or who had killed them (Honwana 1998, p. 105).

In Kavango people who are considered to be suffering from *nyambi ghomathimu* need to go through the drum-ritual ceremony (discussed later in the chapter) and in addition they are given the following medicinal plants; *kayanambo* (*Asparagus nelsii*) to remove the bad spirit, and *mutengura* (*Bobgunnia madagascariensis*) and *mpumutji* (*Euclea divinorum*) to calm them down. The traditional healers' explanations of the causes of *nyambi ghomathimu* are based in social or spiritual realms. For healers and the *muveri* (sick persons) who believe in the traditional health care system, the spiritual intrusion of the *vadimu* (ancestors) is real.

5.4.4 *Kasenge illness*

Kasenge illness is one of the severe mental illnesses and most of the traditional healers remarked that it has existed in Kavango for many years although it is not on record in written sources. The illness has a wide range of symptoms which includes a fear of red colours, red

eyes, crying, withdrawal, inability to concentrate, and saying things which do not make sense, or losing touch with reality, being hyperactive and excessively talkative, as well as running wild and assaulting people. Traditional healers said that although they were able to treat the *kasenge* illness it kept returning (relapsed).

Most of the traditional healers who are able to treat this condition have been the victim of the *kasenge* illness themselves. The majority of the healers maintained that they decided to become traditional healers out of their own interest after suffering from *kasenge*. However, two of my participants told me that they became traditional healers after suffering from the illness following the ancestors' call. The idea that some mental illness like *kasenge* can be a way that ancestors nominate their family members to become healers is also common in South Africa. It is believed that a person can become mad if he/she does not honour the ancestors' call to become a traditional healer and this brings a type of mental illness known as *ukuthwasa* (Niehaus et al, 2004 p. 59). In this regard, the person will be possessed by the ancestral spirits and will scream, shout and dance: it is seen as a culturally sanctioned phenomenon, and as an event with the possibility of improving one's social status by becoming a traditional healer (Niehaus et al 2004, p. 59).

In Kavango, the *kasenge* illness is thus associated with the ancestors' call to become a traditional healer, yet many healers also believe that witchcraft can cause the condition: to the extent that even if a person was treated successfully, they might be visited by the witches later in life causing the illness to return. Some traditional healers believe that permanent immunity can only be acquired if a person becomes a traditional healer since they would go through various rituals to prevent the *varodi* (witches) from visiting the *kasenge* illness on them again. A female traditional healer nicknamed *Kasenge* - because she was considered to be a specialist in treating the illness- elaborated "*kupanga nanyambi ghadimu ghakuyuvhe*" (Heal with God so that the ancestors can hear you). *Kasenge* required a drum beating ceremony which usually takes the whole night, she said;

The ceremony is a public event and community members are expected to partake in singing and clapping hands while the assistant traditional healer (*tungangwena*) beats the

drum and dances. What is unique about the *kasenge* illness is that during the drum beating ceremony the *muveri* (sick person) is expected to collect the medicinal plants him/herself in the field while in a state of trance (*kutumuka*).

Mbambo (2002, p. 128) explained that *kutumuka* (trance) among the Kavango traditional healing is like a form of altered consciousness in which the mental state of the sick is preoccupied by internal degrees of dissociation, as opposed to the normal state of conscious. I argue that in the case of *kasenge* illness, attaining this stage of trance is crucial since it is considered as a sign that the illness is exiting the sick person's head/mind. Secondly, during trance state the sick person's mind is opened up by the ancestors and shown the medicinal plants that are required for his/her treatment.

To illustrate the *kasenge* illness further I share the views of three traditional healers during a focus group discussions held in 2016.

Kandambo³⁶

... *Kasenge* is an old illness and it has existed since time immemorial, even our grandparent suffered from it and it continues to exist in the community. I started treating *kasenge* after I suffered from it myself. Let me tell you and listen very well. I got it via a bad dream. In my dream I saw four people who brought food on a plate, they offered me the food but I refused. But they forcefully opened my mouth and put the food in my mouth. I tried to spit the food out but swallowed some of it. I can still recall and I identify the people I saw in the dream. Two of the men have passed on but the other two are still alive. When I woke up my head was not functioning well, it was disrupted (*mutwe ghunatanghuka*), those who saw me said apparently I was drinking a lot of water and I was all over the place, running around, shouting and screaming non-stop and so on. I was later taken to a traditional healer and he discovered that I had *kasenge*. A drum beating ritual ceremony was arranged for me and during the ceremony I went into trance (*kutumuka*) and I ran into the bushes to collect the medicinal plants myself. Upon my return the traditional healer used some of the medicinal plants as treatment and the rest

³⁶ A female traditional healer who gave her opinion on *Kasenge* during the focus group discussion.

were used later for the duration of my illness. I stayed at the healer's house for some time until I got well. The affected person will usually collect the medication him/her from the forest, river or whatever the case might be. The traditional healer can only collect the initial medicinal plants to calm the sick person. However; the medication that is used for the drum ritual dance must be collected by the *muveri* (sick person). Usually, the drum ceremony takes the whole night and a goat, cow or chicken may be slaughtered. It all depends what the ancestors may require. Some healers are exaggerating nowadays, charging people a lot of money. *Kasenge* can be treated but it is a type of an illness which keeps coming back. It cannot be cured completely. One thing about *kasenge* is that it not only causes disruption of the person's head, at times the person's legs, stomach or hands might be swollen or it might just cause generalized body pain .

Mukoya³⁷

... *Kasenge* is a type of *ghupurumuki* (madness) similar to *ndjangura* type of madness. The *muveri* (sick person) will have red eyes and will be in a disoriented/confused state of being. The person cannot relate naturally/normally to the people and his surroundings because he/she is affected by bad spirits of the ancestors or witchcraft. The ancestors can attack anyone in the clan as long as you belong to that particular clan. They will just know you are one of them. Just think how come a person born today can resemble someone who have died long time ago even before the birth of the parents of that person? It works in the same way. The *Kasenge* illness requires the drum healing ceremony since it is caused by witchcraft. During the ceremony the witch must be put to shame and asked to leave the (*muveri*) sick person spirits. During the ceremony we put water and medication (*mutondo*) on a white bowl which the sick person uses to splash his/her body during trance (*kutumuka*) which is part of the treatment. For *Kasenge* we make use of the following plants, *mutengura*, *muyambiyambi*, *ushivi*, *utu*, *ghutimba*.

Weka³⁸

³⁷ Male traditional healer who gave his opinion on *Kasenge* during the focus group discussion.

³⁸ Male traditional healer who gave his opinion on *Kasenge* during the focus group discussion.

... *Kasenge* is another type of madness and it has been around for a very long time and it can be invoked by the ancestors and at times it can be cast upon a person by the witches. People might hate each other, bad talk one another or they are not looking after one another. So there are some forms of disunity in the clan that need to be restored. The bad spirit (*mpempo yayiona*) is the one that causes the person to go mad and do all sort of bizarre things because the person's body is not at peace. Usually the person will be running around and talking nonsense. In actual fact the bad spirit will be the one talking since the person is possessed by the bad spirits. The *kasenge* sufferers will also have red eyes and of course the *katemba* (oracle) will definitely pick it up. The treatment of *kasenge* requires a drum beating ceremony and any person is welcome to attend the ceremony. But *kasenge* treatment is very much similar to that of *ndjangura*. During the focus group discussion traditional healer's explained *Ndjangura* illness as follows;

5.4.5 *Ndjangura* illness

Traditional healers view the symptoms of *ndjangura*, its causes and treatment, as very similar to that of *kasenge*. The causes are believed to be supernatural: a *muveri* (sick person) is inflicted by contaminated/bad air (spirit) (*mpempo yayidona*) of the witches. Such a person's behavior will then be characterized by fear of the colour red, crying, withdrawal, inability to concentrate, and saying things which does not make sense, a loss of touch with reality, being hyperactive and unnaturally talkative, and being aggressive. The person may also have physical signs like red eyes, fever and headache. The treatment can range from the administering of medicinal plants such as *munyangathena*, *mutengura* and *muthimbathimba*, *ushivi*, *utu*, *ghutimba*. These medicinal plants are administered to the eyes and ears as drops, locally known as *kushotja*³⁹, by steaming (*kufika*), and followed by a drum beating ceremony (*kuvetera ngomba*).

Although both *ndjangura* and *kasenge* are very similar in their manifestations traditional healers were able to make the distinction between the two, as Weka explained below.

Ndjangura is mainly caused by witchcraft and here the use of *katemba* is very much

³⁹ *Kushotja* is the process of administering drops of herbal medicine into the eyes or ear.

crucial in identifying and differentiating the two. While the drum ceremony in both cases is vital but for *ndjangura* sufferers one has to induce vomiting since the person has been bewitched and at times given something to eat via the dream...so a *ndjangura* sick person must vomit during the ceremony it is not enough to just go into the trance. We make use of *mutengura*, but do not try it because you will not know how much to give. You might even cause more harm.

In the next section I discuss the ritual ceremony locally known as *kudjamba* (to sacrifice) which normally takes place at the shrine (*vanganga* secret place). Insoll (2011, p. 145) explained that the term shrine derived from the Latin word *scrinium* meaning ‘box’ or ‘receptacle’, as in ‘containers of sacred meaning’ and power of spirits or entities. For the healers in Kavango, the shrine (*shinako*) is seen as a secret place where they conduct their healing rituals while communicating with the ancestors. I describe what I observed there. I will present the case of the healing ritual of the *muveri* (sick person) who was diagnosed with the *nyambi ghomathimu* (*Nyambi* that has been caused by ancestors), including what happened in the ceremony and how I took part by helping with the preparation.

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5.5 The *kutjamba* ceremony of a mentally ill person (*Nyambi* caused by Ancestors)

Before I discuss the healing ritual ceremony let me describe the *shinako* (shrine). It is situated inside the homestead of the healer (figures 7 and 8 below) and contains a number of items which traditional healers use for the healing ceremony. These include *marudeve* (reed skirts)⁴⁰ which the healer wears around his/her waist while dancing to the rhythm of the drum during the healing ceremony. It also has *tjapo* (a ritual medicine container)⁴¹, a table cloth to cover the *katemba* (divination device) and an oxtail which is used to sprinkle hot water with *mutondo* (medicine) on the *muveri* (sick person).

The ceremony took place while I did fieldwork with Shamwaka, a male senior traditional healer. Since traditional healers treated me as a *kangangwena* (junior traditional healer) I helped in the

⁴⁰ In the far right corner of figure 7

⁴¹ *Tjapo* is the plastic container on the wooden table in figure 7 with red powder (medicine) in it.

preparation of the ritual. Ndara, Kative and I started by cleaning the shrine area. Later we went to collect some firewood for the ritual. It took place in the evening soon after sunset. A few minutes before the ceremony started Ndara brought a big clay pot with various medicinal plants (mainly roots with a few leaves) inside the shrine. We put five white plastic chairs beside the fire as well as three reed sleeping mats (*Matjaro*). The family of the *muveri* (sick person) arrived with a black goat. We tied the goat to a tree in the corner of the shrine. Later Kativa arrived with two sharp *ruforo* (sword)⁴² with double-edged blades and an old grey zinc bowl.



Figure 7 Ndara and Kativa at *Shinako* (shrine) secret space

⁴² traditional knives

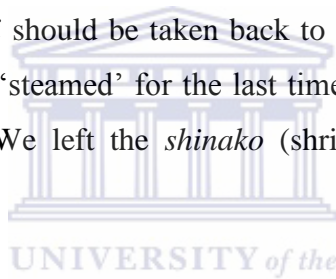


Figure 8 Michael shirungu (researcher) with Ndara and Kativa at *Shinako* (shrine) secret space

Ndara assured us that the shrine was ready and the family members were called inside the enclosure and seated. Shamwaka joined us later and he took the *tjapo* and put some black oil and medications inside. The *muveri* (sick person) was brought and positioned in the middle of the shrine, next to the fire with his hands tied together. “*Tutameke keho*” (let’s begin now) Shamwaka told us. Ndara and Kativa grabbed the goat and pulled it to the ground on an old cattle hide. They cut the goat open and through its ribcage they pulled out the heart. The goat did not bleat as its mouth and nose was held tightly closed. The blood was poured into the bowl. The goat heart was handed to Shamwaka on a wooden plate. He then stood up from his chair and said:

My elders, my ancestors I hope you can hear me and I hope you are with us this evening, I beg of you to please have mercy on the *muveri* and at the same time accept our offering to you. Kindly, accept the forgiveness from his mother’s side whose hearts are not at peace with him, but they are here to ask for your forgiveness.

Afterwards he put down the plate with the heart next to the fire; the heart was still making some movements. Then he took the *tjapo*, lit it and started swinging the *tjapo* around the sick person (*muveri*) while repeating the same words he had said earlier. Then he called all the family members who were present to carry out the same procedure and repeat the same words. Later, Shamwaka took the black oxtail and dipped it into the pot which Ndara and Kativa had removed from the fire. Shamwaka then hit the oxtail against his left hand and in the process sprinkled the hot water on the body of the *muveri* - who was still lying on the reed mat on his left side. The *muveri* screamed but Shamwaka repeated the action several times. When he was done Kativa poured some of the water in the bowl and everyone who was present was asked to wash their hands. The remaining water was used to steam the *muveri*. At this time Kativa and Ndara put the *muveri* in a sitting position on the mat and covered him with a blanket, together with the pot full of medicinal plants. Later Shamwaka announced that the ceremony had come to an end and informed everyone that the *muveri* should be taken back to his room. He further noted that in the morning the *muveri* would be 'steamed' for the last time and afterwards he would receive the rest of his treatment orally. We left the *shinako* (shrine) and everybody went to their respective places.



It was apparent that the three most common types of mental illnesses are (I) *nyambi* illness with the three subtypes, (II) *kasenge* illness and (III) *ndjangura* illness. Nevertheless, one has to be very careful on how to address or present these conditions, as Shamwaka warned me when I shared my field notes with him, after being with him and his assistants for three months. He remarked:

Maika there are different types of *kughundumuka* (madness), but some of the mental illness you must examine them with caution. For example you know about the two boys who came in two weeks ago? Their mental illness is due to drug abuse (marijuana) locally known as *lipangwe*. You see I cannot tell you the local name for their mental illness but they were completely mad upon arrival. But the problem with these young boys is that when they go back home or school they will start smoking again and they will relapse.

I did not omit any of the illnesses or concepts which might indicate or translate to mental illness in Kavango. Rather, I scrutinised my ethnographic materials and have chosen to focus on the most pertinent and common ones which seemed to stand out in my daily interactions with the traditional healers as they handled *muveri* and their family members. Until now no literature has described such meanings and interpretations.

5.6 Conclusion

In this chapter I have discussed traditional healers' local notions of mental illness in the two Kavango regions. In particular, I have discussed the three common mental illness conditions namely; (1) *nyambi* illness (2) *kasenge* illness and (3) *ndjangura* illness. I have argued that these mental illness categories are not fixed or objective but differ in terms of the basic underlying assumptions and their manifestations which influence each traditional healer's mode of explanation and treatment (Long and Zietkiewicz 1997, p.7; Foucault, 1967). In this regard, the *vanganga* in Kavango construct mental illness based on the diagnostic methods (*katemba* divination device) used. They operate in the local indigenous healing system and use spiritual forces as a mode of communication with the ancestors to determine the cause of the conditions and identify the illness. As such, mental illness is variously seen as a sign that the family has deviated from cultural norms causing the *vadimu* (ancestors) to be angry, a form of harm instigated by a jealous third party (witchcraft) or a physiological problem (Teuton et al 2007,p.1262). While traditional healers view mental illness as a physical illness that causes disruption of mind/head/brain, they also see it is as a social deviance which provoke or anger the ancestors to impose illness on an individual, or as a result of witchcraft. Social disruption is believed to be caused by angry (*vadimu*) ancestors and (*varodi*) witches who are believed to be the key players in the cause of mental illness. I have also shown that the *vanganga* (Traditional healers) restore the social order at family level through the Kutjamba ritual ceremony, while at the community level it is done through the *kuvetera ngoma* (drum beating ceremony)

CHAPTER SIX

6 MEDICINAL PLANTS USED TO TREAT MENTAL RELATED ILLNESS IN KAVANGO REGIONS.

There is a dearth of scholarship on the interface of ethnobotany and medical anthropology, which is surprising considering that plants are usually used by traditional healers as medicines for rituals and treatment (Hsu and Harris 2012, p. 23).

6.1 Introduction

The above quote illustrates that although anthropologists show an interest in traditional healing and produce numerous ethnographic studies on traditional healing, few pursue medicinal plants as a serious subject of inquiry. Instead, the bulk of the studies tend either to overlook or downplay the role of medicinal plants in traditional healing. A quick search on medicinal plants studies in *Medical Anthropology Quarterly* journal, for example, gives the date of the latest study as 2008. The majority of more than 70 internet “hits” on the subject list medicinal plants as a category, but give little detail on which plants this involves, how they are used, and in what contexts (Heckler 2008, p.44). This failure of anthropologists to engage deeply in plant studies neglects a core mission by allowing something vital to remain mostly under researched (Kaufman 2015, p.16).

The majority of studies that focus on medicinal plants are in ethnobotany or other fields. Despite the fact that the daily use of medicinal plants, their related cultural history, uses and practices, attract the interest of the scientific community, there has been scant research on the interface of ethnobotany and medical anthropology (Hsu and Harris 2012; Sood et al 2001; Ellen 2006). This chapter is a particular effort to close some of the gaps in this body of knowledge in the field of medical anthropology in the Kavango regions where I did my fieldwork. It attempts to locate the epistemology of traditional healing concerning the use of

medicinal plants as treatment for mental illness. Plant knowledge and its use among traditional healers is explored and the emphasis is on medicinal plants utilized to treat various mentally related illnesses, as well as how the plants are administered.

Part of my argument in this chapter concerns the power of medicinal plants to prompt the interest of a number of anthropologists who focus on plants (Cohen 2015; Green et al, 2015, p.7; Gibson 2010, p.56). My argument is that these plants are understood to possess powers in themselves, but these powers need to be “enticed or seduced” by the healers in order to produce a therapeutic effect on the *muveri* (sick person). My contention is also that medicinal plants have transformative abilities which are often inherent, but can also be ‘activated’ by the community and people who utilize them (Hsu and Harris, 2012, p. 24). Thus, I will show that plants have intrinsic power that work at different levels in traditional healing to treat a particular illness. It was evident in the research that every adult in the community knew and used numerous plants, locally known as “*vitodondo/mutondo*” medicines, and this knowledge was strongly embedded in local cultural practices, ways of knowing and beliefs: with the focus of healing being on the whole person or being rather than just the biological aspects of disease (Das 1996, p. 24).

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6.2 Medical pluralism in Kavango regions

Güler et al (2015, p.103) noted that medicinal plants have been used by local communities as a source of medicine since the dawn of humankind in different parts of the world. Kavango, like most contemporary societies, has a pluralistic system of health care where modern scientific biomedicine coexists with multiple local therapies of traditional medicine (Chinsembu et al 2015, p.34; Shirungu 2015, p. 273; Gibson; 2009, p. 29). “Traditional medicine” in the broad sense includes a diversity of health practices, approaches, knowledge, and beliefs which make use of plants, animals, and mineral-based medicines; spiritual therapies; manual techniques and exercises, applied individually or in combination, to maintain well-being, as well as to treat, diagnose, or prevent illness (WHO 2001, p.80). By biomedicine I mean medical practice that is sometimes called Western medicine, scientific medicine, or modern medicine (WHO 2001, p.80), which has become a hegemonic way of understanding, diagnosing and treating ‘disease’

in most African countries (Meincke 2015, p.91). People in Kavango make use of both health care systems. Lock and Nguyen (2010, p.63) outlined a number of reasons why individuals select one type of practitioner over the other;

- i. The kind of disease or affliction that needs attention;
- ii. Local beliefs about the cause, cure, and appropriate curer for a specific problem;
- iii. The economic and social status of the patient and her family, and
- iv. The kinds of advice and information available at the time a particular strategy is adopted.

They argued that the extent to which medical traditions other than those of biomedicine continued to flourish and the fact that people everywhere in the world frequently consulted more than one type of medical practitioner provide incontrovertible evidence that biomedicine alone is not sufficient to meet the needs of vast numbers of people. In this regard, lack of economic resources nationally to build health care facilities and the inability of some patients and families to pay for biomedical care, account in part for thriving indigenous medical practices. However, even where biomedicine is readily available, many people use a pluralistic approach when dealing with illness and disability. A number of studies shows that patients and families often prefer to go to local healers even when a visit costs more than one to biomedical practitioners (Chinsebu et al 2015, p.34; Shirungu 2015, p. 273; Lock and Nguyen 2010, p.63; Reihling (2008, p.2)

Following Namibia's independence in 1990, major restructuring has been undertaken under the Ministry of Health and Social Services (MOHSS) to increase delivery of health services to all, rather than the pre-independence fragmented system. Biomedicine comprises the main form of State health care provision (Shirungu 2015, p. 273), but traditional healers also provide health care services to the great part of the population living in both rural and urban areas in Kavango. In this regard, the World Health Organization (WHO) noted that approximately 80% of the populations of developing countries relied on traditional medicine for primary health care (WHO, 2002). This 80% usage in developing countries has been questioned and I cite it with caution. Whatever the precise extent of local use, medicinal plants remain popular despite the growth and development of the country's pharmaceutical industry (Güler et al 2015, p.103). In

the Kavango region traditional healers continue to be consulted for a variety of reasons. In many cases both systems come into play and dual treatment regularly takes place (Chinsebu et al 2015, p.34; Shirungu 2010; 2015; Mbambo 2002; Lumpkin 1994, p.65).

Anthropological convention suggests that modernization weakens and erodes traditional knowledge in predictable ways (Quinlan and Quinlan 2007, p.173). In this regard, Lock and Nguyen (2010, p.64) noted that a considerable amount of integration, syncretism, and borrowing has taken place between indigenous and biomedical practitioners over the past century, and a large number of indigenous healers have adapted to the new global reality, often adding one or more biomedical technologies to their repertoire. They further argued that at times such adaptations are the result of pressures placed on healers directly or indirectly by governments to systematize and standardize their practices and to “biomedicalize” themselves. Equally, traditional healers are not immune to the effects of a world where television and the internet inform people everywhere about what is in their own best interest. Unsurprisingly, traditional healers also “modernize” their practices and package their wares to attract buyers. Modernization and the spread of biomedical knowledge have dramatically affected the knowledge, explanatory accounts, and practices of indigenous medical practitioners wherever they exist.

People in Kavango have been exposed to biomedicine since the early 20th century when the first missionary settled at Nyangana mission station in 1910, 100 kilometers east of Rundu. Thereafter a hospital was built and the first trained medical doctor was appointed in 1936 (Lindhout 2000, p.30). Other district hospitals followed at Rundu, Andara and Nkurenkuru (Biesbrouck. 1999, p.20; Delimitation Commission Report, 1998). Today the Kavango regions have Rundu State hospital as the referral hospital, while Nyanganga, Andara, Nankundu and Nkurenkuru serve as district hospitals. In addition the regions have health centres and clinics.

Although traditional and Western health systems have operated concurrently since the 1920s, biomedicine has enjoyed official acceptance in terms of funding and investment because it is based on scientific knowledge, whereas traditional healing is perceived to be based on beliefs, rituals and the practice of witchcraft (Rautenbach 2015, p.23). Christianity, introduced under colonialism, led to traditional healers being regarded as “witchdoctors” who exploited the

ignorance and superstition of the “unenlightened local people” (Rappaport 1980, p.81). This was also the case in Kavango as Haingura (1993, p. 183) noted.

In general, missionaries put a Christian revolutionary demand to their converts and members of society: Kavango people should throw away the traditions, beliefs and customs that clashed with Christianity and accept a new way of life, social code and morals. They should reject their *Vahompa* (kings), chiefs, medicine men, rainmakers and their non-Christian families and relatives. Many missionaries condemned the religion, rituals and dancing that was alien to their concept of religion.

Equally, colonial administrations prohibited traditional healing and condemned them as “heathen” and “primitive” (Ulin and Segal 1980, p.1). In Kavango a number of traditional healers were arrested and in 1960 a popular traditional healer by the name of Kayimana died in a Rundu police cell following his arrest by the colonial government for practicing traditional healing (Mberema 1996, p.78).

Little is known about the approach of traditional healers or their use of medicinal plants, or ritual methods and psychosocial treatments based on local “traditional” healing methods, to address common ailments (Shirungu 2010, p.65). Modern medical facilities and traditional healing co-exist, as Reihling (2008, p.2) shows, and access to information and education based on “scientific facts” does not replace local understandings and health practices. He argues that while some local medical treatment regimens may vanish over time, others may be transformed, revitalized and reinvented. Both health care systems have a number of shortcomings.

In academic discourse traditional healing may be presented as dynamic and fluid, but the traditional healers and the local people who use it, consider it to be static and unchanging. For example when I asked traditional healers about the rationale for their healing practice e.g the selection of plants, dosage and ritual healing among others, I was told that it was “culture” (*mpo*) and its content has been passed from one generation to the next. Akuupa (2006, p.5) explained that “*mpo*” is generally used by older people to refer to something that is old and different from the modern, in other words, it was viewed as synonymous with tradition

(Shirungu 2010, p.49). However “mpo” is seldom utilized alone: it is generally linked to “zetu”, meaning ours. The phrase “our tradition” thus signifies something that carries the authority of the past and that is associated with a particular population. Moreover “*mpo zetu*” is commonly used to refer to practices that are assumed to have been handed down for generations and need careful protection against “foreign” influence (Akuupa Ibid).

Traditional healers routinely struggle to deal with contemporary illnesses such HIV/AIDS, tuberculosis, cancer, diabetes etc, since it is seen as something new to traditional healing. Secondly, the traditional healers’ process of the transfer of knowledge is fragmented. Since such knowledge is not systematically documented, it can also be lost, as shown in chapter 4. Thirdly, traditional healing cannot deal with, for example, acute emergencies such as injuries due to car accidents or gunshot wounds, and it struggles to manage many contemporary health issues. But the biggest challenge is the absence of government assistance in mapping out legal guidelines⁴³, or the kind of collaboration between the two health care systems which could lead to traditional healing being accepted as a health care system of knowledge, practice and therapy.

On the other hand, despite huge investment in biomedicine it also has several shortcomings, including a general shortage of personnel, and huge geographical discrepancies in access to health care facilities. The State’s health services are at times culturally ill-suited to handle e.g. culturally-bound syndromes, as in the case of certain mental illnesses. Culturally-bound syndromes are conditions that are linked to a particular community and cannot be dealt with in hospital settings, for example the cleansing rituals for three common mental disorders, as discussed in chapter five, cannot be carried out in the hospital setting. The rituals embraced by the local people in the treatment of mental illness are not taught in medical schools. Secondly, biomedicine is based on scientific knowledge so it does not make sense to conduct e.g. rituals in hospitals. Instead, traditional healing could complement biomedicine.

In a recent publication Chinsebu et al (2015, p.34) noted that continued reliance on traditional healers by the Kavango people originated in historical disadvantages: the two Kavango regions are home to Namibians who struggle with inadequate access to health services (United Nations

⁴³ See chapter four on the legal status of traditional healing.

Development Programme, 2000). Kavango is the fourth most populous region in the country with a population of 223 352, accounting for 11% of the total national population (Namibia statistical agency 2011, p.28). In 2011 the Kavango region had the highest incidence of poverty of all regions at 53% (ibid). Chinsembu et al (2015, p.34) argued that in Namibia, one of the most sparsely populated countries in the world, traditional healers are more geographically accessible than public health facilities. Such sentiments were also shared by Lumpkin (1994: 65) who argued that local people visited traditional healers since they were most frequently closer to home than the state health care system.

People also visit traditional healers for reasons other than physical ailments. When I spoke to one of the nurses who previously worked at the Shinyungwe clinic on his motives for visiting (Shamwa) the traditional healer, he had this to say⁴⁴:

Bra, I became sick while I was working at the clinic as a nurse, literally I was paralysed. My legs became numb and I would not move or feel a thing, I had severe backache it was terrible bra. I spent two weeks at Nyanganga hospital and later I was transferred to Rundu state hospital where I was seen by different specialists who treated me and did numerous tests from x-rays to blood tests, but could not find the cause of my illness. I was put on some antibiotics, analgesics and a daily exercise with physiotherapy. Well, the pain lessened but as days passed I was worried if I could ever walk again, the doctors told me there was nothing wrong with my spine or any bone structure in my body and they suspected some unknown infection had affected my nerves- but I was terrified as day passed by and my family members were also very much worried. Some of them suggested that I should be taken to the traditional healer while others were of the opinion that I should visit one spiritual healer at the Pentecostal church. From the beginning I did not entertain the idea but later I started to give in and I told my mother that I was willing to see the traditional healer. I requested for a transfer to Nyangana hospital since it was close to home and the doctors did not resist my request. While at Nyangana hospital I asked the doctors for some time to go home and come in to collect my medication when necessary. My family members took me to a traditional healer after I was discharged

⁴⁴ Informal discussions with Boniface Mudumbi a former enrolled nurse at shinyunge clinic situated 120 kilometers east of Rundu. He is currently, working for Lady Pohamba private hospital in Windhoek as an enrolled nurse.

from the hospital. According to the traditional healer through his *katemba* I had a blood clot in my back so he had to remove the blood clot. The clot was believed to be caused by the jealous people in my family. He used a blade to cut on the side of my back⁴⁵ and took the horn of the cattle to suck the blood out⁴⁶. Look here bra the marks are still here (as he was pointing at the backside where the incisions were done). In addition I was given some medicinal plants which I was taking concurrently (with) the antibiotics from the hospital and I used to get a traditional body massage as well. On the second week I could feel my legs and later I started making some movement and within three months I was able to work (walk) on my own. Bra if you are studying traditional medicine that's good.

Mudumbi's story illustrates that patients visit different health care system in search of a cure and at times they utilize both systems to maximise and speed up the recovery. In some instances, as in Mudumbi's case, it worked- but in others it might pose danger or even make the condition worse, inter alia as a result of drug-plant interaction.

As I indicated earlier, the possibility that I might be suspected of witchcraft myself as a result of my work with traditional healers came up a number of times during the study. For example, I interacted with Matizo, who collected a mentally ill person from Shamwa, a senior traditional healer as I note in chapter five. Once, when I started to talk about my research with traditional healers, Matizo said to me

Maika be careful very soon you will become a witch (*maika takamita ntatani ghuturo ghurodi ve*).

I asked Matizo his reason for removing his cousin from the traditional healer's place and he responded:

My cousin is mad and he is on treatment already. His madness normally relapses when he start drinking alcohol because he does not take his medication when he consume alcohol.

⁴⁵ The process is referred to by the traditional healers as *Kushata* (incisions). The *nganga* normal make use of the blade to make small cuts on the patient so that dirty blood can come out. Following the incisions the *nganga* will apply some medicine to stop the bleeding and prevent wound infection.

⁴⁶ This process is known among the traditional healers as *kushuyika* which is an extensive sucking of the blood clots from the patient.

I just do not understand why his wife took him to the *nganga* (traditional healer) in the first place?...my cousin's condition can only be managed better at the hospital, not by *shamwa*. I mean look my cousin went back to his work place now: he must just take his medication on a daily basis, period, nothing else.

From the above two scenarios it is also evident that people in Kavango make use of both health care systems, and patients⁴⁷ or *muveri*⁴⁸ move between these health care services in search of a cure for their conditions. People in Kavango use medicinal plants either before seeking access to biomedicine, or as part of dual treatment. In Kavango a distinction was made as to which illness should be taken to a hospital and which one was for traditional healers. Although traditional medicine could be regarded as a cultural practice among people in Kavango, they also used it when they did not have access to biomedicine, or lacked money for transport to the nearest health centre, or to pay the clinic's fees: thus, People in Kavango were bound to use medicinal plants as alternatives. This was particularly the case for people with mental illness. The lack of psychiatric services in Kavango is related to what the physician anthropologist Paul Farmer called structural violence. He (2003) referred to it as:

The social arrangements that put individuals and populations in harm's way... The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people ... neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress.

Farmer's idea resonates particularly with the Kavango region and to mental illness. As Farmer (2003, p.24) argued, structural violence is often hard to see and difficult to identify, so that people can be held responsible for it. For instance when a mentally ill person dies at home under the care of the family members, or dies at the place of the traditional healers, the question

⁴⁷ As referred to in biomedicine.

⁴⁸ As referred to in traditional healing.

arises of who is to blame. In many cases government officials may cite “culture” to justify people’s use of traditional medicine but in reality the local health care services do not cater for specific needs such as mental illness. Gibson (2010, p.53) warned about the idea of “culturalism” when the state does not provide the service needed by the people, and resorts to the idea of “culture” as a barrier to health care delivery (see Lock and Nguyen, 2010). Gibson (2010, p.53) argues that “culturalism” involves a form of “decontextualised blaming of the patient” and puts the responsibility for health care failure on the sufferer instead of the provider; thereby ignoring the influence of poverty, discrimination and systemic injustice. Thus, it turns attention away from the social, economic and political basis of poor health among marginalized groups (Greene 2004, p.402).

In Kavango mental health care services are absent in rural areas - where the majority of the poor live. Although the use of traditional medicine for mental illnesses among the Kavango people is indeed part of their cultural practices, the absence of health care services simultaneously leaves people with no alternatives. Traditional medicine is the only available form of health care that is convenient and accessible. This was also reported by Gibson (2010, p.56) in Tsumkwe, in the Otjodzondjupa district in Namibia, among *Ju/’hoansi* speakers who use traditional medicine to treat the symptoms of tuberculosis because of a lack of formal health care.

In Kavango people also seek care from the traditional health system because of shared understandings of causation, or classification of the moral or spiritual aspects of the condition or ailment (Herselman 2007, p. 64). Furthermore, Gibson (2009,p.29) argues that the diverse types of knowledge involved in sickness and the search for health are imbued with relations of power: as I indicated earlier, the ability of state health care providers to diagnose and treat mental illness in Kavango is not the same as it would be in Windhoek, the capital. In the case of traditional healing, diagnosis and treatment must be offered by a *nganga* or a *nkurunganga*: some traditional healers are nonetheless seen as more powerful than others. Yet healing knowledge is also translated and hybridized in different settings. Thus, experiences of the ill (and their families), as well as healing knowledge should be analyzed in a continuous and fluid interaction between the local, national and even global levels (Gibson 2009, p.29, Green, 2008, p.149). In the next section I discuss how plants are used to treat mental illnesses of

muveri (sick persons) in particular and their family members in general.

6.3 Medicinal plants used to treat mental illnesses

A total of 37 medicinal plant species belonging to 24 families were used to treat mental illnesses. The most reported plants in this study were *Albizia tanganyicensis*, *Ancylanthos rubiginosus*, *Bobgunnia madagascariensis*, *Dialium engleranum*, *Diospyros virgata*, *Elaeodendron transvaalense* and *Guibourtia coleosperma*. The most dominant families in the study were Fabaceae (8 species), Ebenaceae (3 species), Combretaceae, Dichapetalaceae, Celastraceae, and Burseraceae (2 species). Fabaceae species have psychoactive effects and have been reported to be used for mental illness in indigenous healing in Southern Africa (Sobiecki, 2002, p.67). Based on their selection and use of medicinal plants, traditional healers in Kavango seem to have some ethno-pharmacological knowledge.

A search of the literature shows that most of the medicinal plants that traditional healers use for mental illness were reported by other scholars to have psychoactive effects, such as sedatives, euphoricants, stimulants and soporifics (Coleta et al 2008, p.44). Psychoactive chemicals affect the central nervous system in several ways by impacting the release of neurotransmitters such as acetylcholine, or by imitating their actions (Sobiecki, 2008, p.13). Ratsch (2004, p. 4) remarked that in the treatment of mental illness traditional healers use psychoactive plants which enhanced intuition, sensitivity, trance and lucid dreaming among the patients. Plants which traditional healers in Kavango use such as the Acacia species were also reported to have psychoactive effects on patients in other countries. For example in West Africa the bark of *Acacia campylacantha* is used as a psychoactive additive known as *dolo*, which is brewed from sorghum, millet and honey, the beverage is believed to impart strength and boost the mood of the depressed patients (Ratsch, 2004,p.22). Traditional healers in Kavango used some of these plants to treat the three common mental disorders (CMD): *nyambi*, *kasenge* and *ndjangura* illness⁴⁹. The mode of preparation for all treatment is shown in Figure 3 below. In this regard, boiling plant materials was used method most often to prepare medicinal plants prescriptions (86%) followed by crushing (8%) the plant parts into powdered form, and then finally soaking

⁴⁹ See chapter five on the discussions around the three common mental disorders.

them.

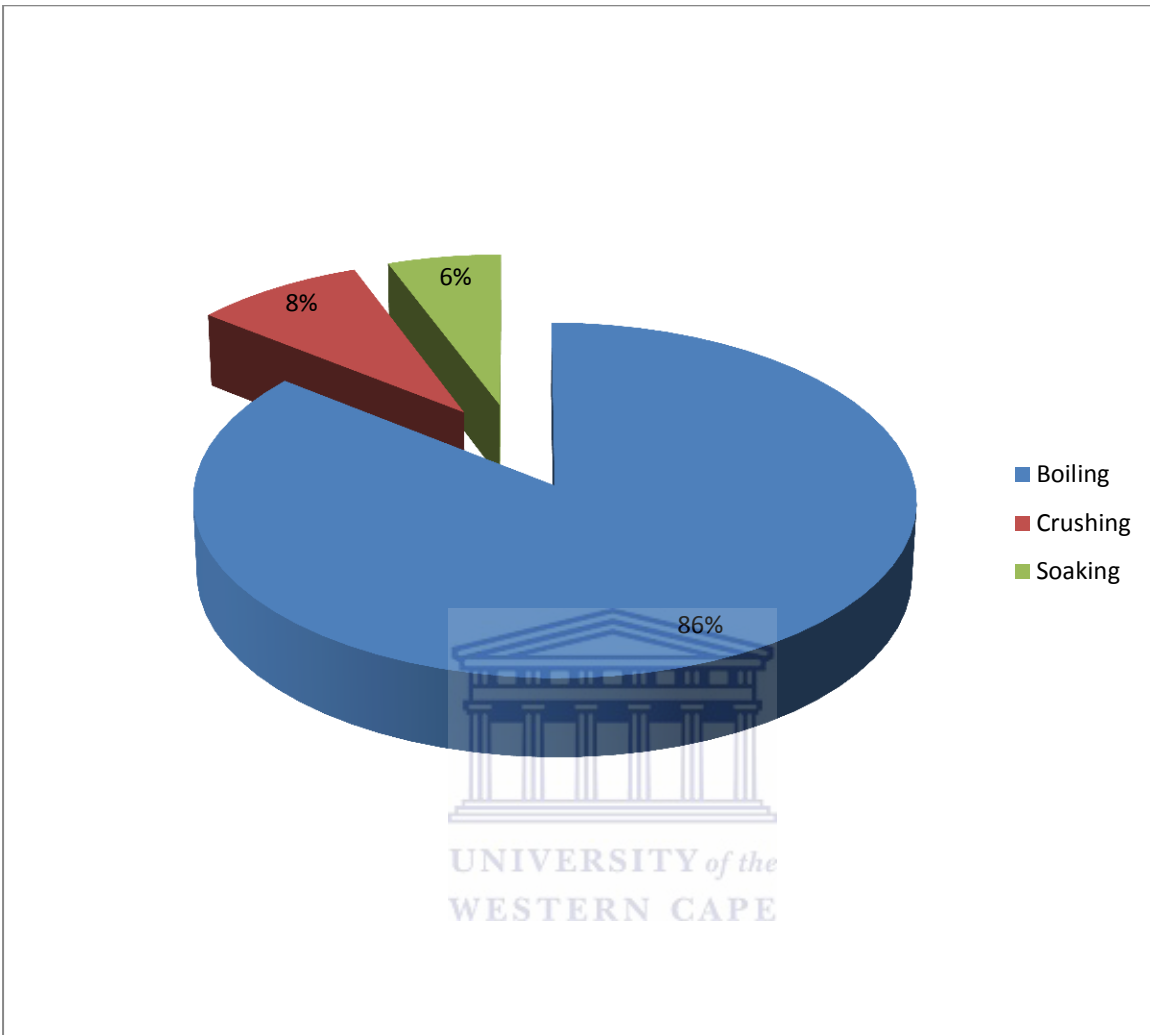


Figure 9 Mode of preparation for medicinal plants treatment by traditional healers in Kavango regions.

Traditional healers prepared medicinal plants in various forms. It was found that 72% of medicinal plants were used both fresh and dry, with 14 % used fresh and 14% in dry form (see figure 10 below).

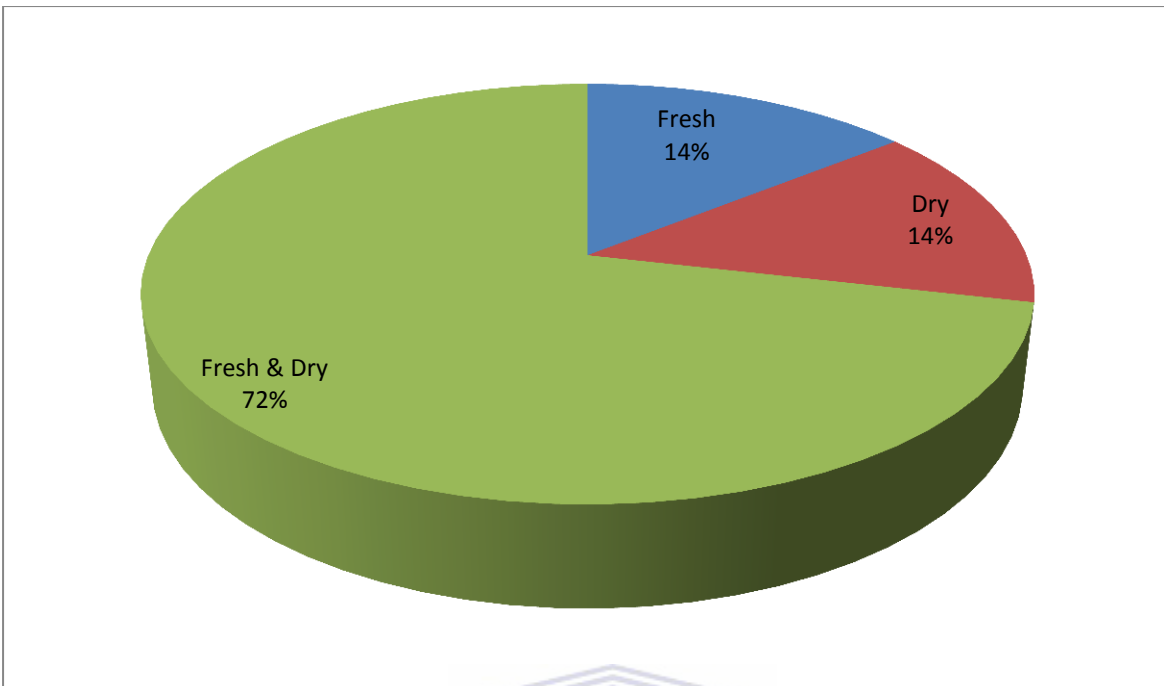


Figure 10 Status of use for medicinal plants used by traditional healers to treat mental illness in Kavango regions

Different plant parts were used in various ways. In this regard, a combination of roots and leaves (77%) were most frequently used for treatment of all reported mental illnesses. This was followed by roots (14%), leaves (6%) and tubers (3%). See Figure 5 below.

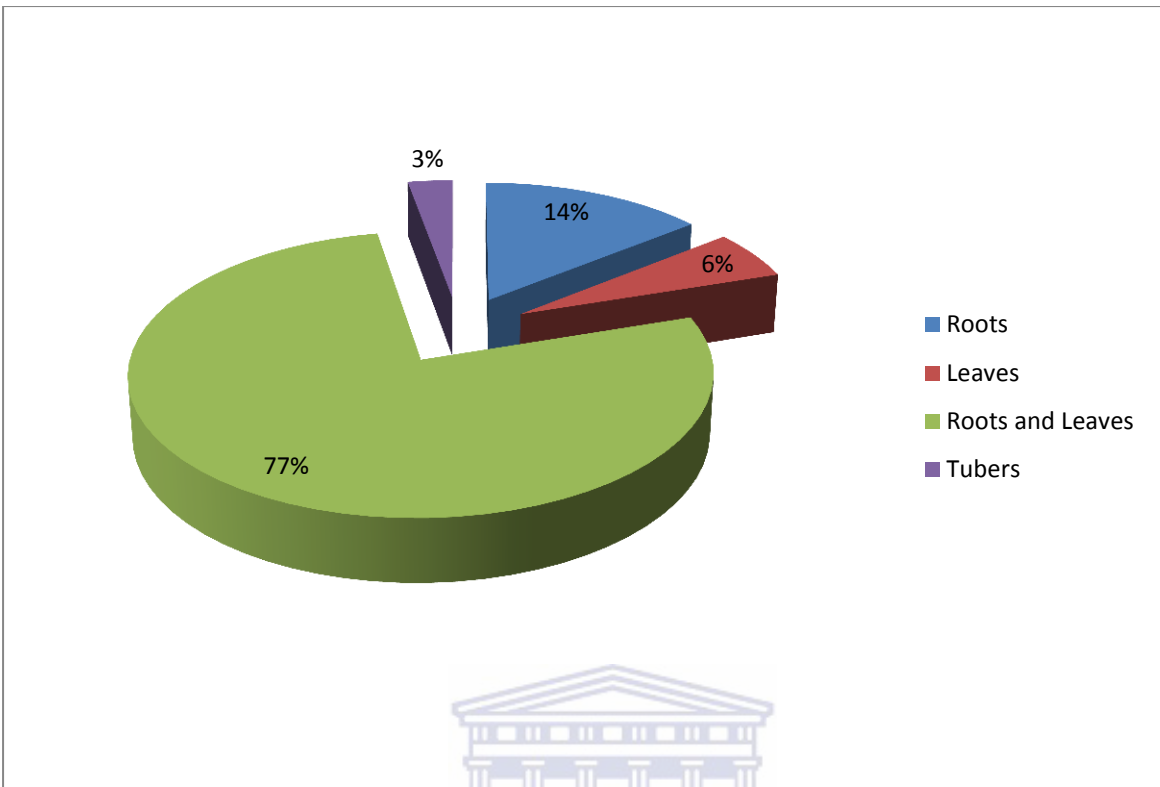


Figure 11 Percentile distributions of medicinal plants parts used by traditional healers in Kavango regions.



Below is Table 3 with medicinal plants used to treat mental diseases/ailments in Kavango regions with a number of species according to their taxa of families, local names, specimen voucher number and the time of recovery.

Table 3 Medicinal plants used to treat mental diseases/ailments in Kavango regions, Namibia

Scientific name	Family	Local Name*	Voucher Specimen No.	Time of recovery
<i>Combretum</i> sp.	Combretaceae	<i>Murenga</i>	IKSTF0529	One week
<i>Strychnos spinose</i>	Loganiaceae	<i>Uguni</i>	IKSTF0549	2-3 weeks
<i>Elaeodendron transvaalense</i>	Celastraceae	<i>Mupuko</i>	IKSTF0532	2-3 weeks
<i>Acacia erioloba</i>	Fabaceae	<i>Ghuntu/untu</i>	IKSTF0538	2-3 weeks
<i>Ficus glumosa</i>	Moraceae	<i>Ghukuyu</i>	IKSTF0556	Two days
<i>Laggera decurrens</i>	Asteraceae	<i>Lindindinyime</i>	IKSTF0563	Two weeks
<i>Ancylanthos rubiginosus</i>	Rubiaceae	<i>Mpindu</i>	IKSTF0540	One week
<i>Diplorhynchus condylocarpon</i>	Apocynaceae	<i>Murere</i>	IKSTF0552	One week
<i>Ozoroa longipes</i>	Anacardiaceae	<i>Mukanga</i>	IKSTF0520	One week
<i>Pseudolachnostylis maprouneifolia</i>	Phyllanthaceae	<i>Mulyavambi</i>	IKSTF0533	One week
<i>Cardiospermum grandiflorum</i>	Sapindaceae	<i>Karenga</i>	IKSTF0557	Two weeks
<i>Ehretia namibiensis</i>	Boraginaceae	<i>Muyenge</i>	IKSTF0527	2-3 days
<i>Securidaca longipedunculata</i> Fresen	Polygalaceae	<i>Muviyu</i>	IKSTF0565	One week
<i>Annona stenophylla</i>	Annonaceae	<i>Muroro</i>	IKSTF0566	One week
<i>Combretum platypetalum</i>	Combretaceae	<i>Mukongo</i>	IKSTF0567	One month
<i>Commiphora angolensis</i>	Burseraceae	<i>Muvovo</i>	IKSTF0539	3-4 days
<i>Dialium engleranum</i>	Fabaceae	<i>Muthimba</i>	IKSTF0551	Two days
<i>Ximenia americana</i>	Olacaceae	<i>Mpeke</i>	IKSTF0542	1-2 days
<i>Diospyros virgata</i>	Ebenaceae	<i>Nyambi</i>	IKSTF0544	One month

<i>Bobgunnia madagascariensis</i>	Fabaceae	<i>Mutengura</i>	IKSTF0530	One month
<i>Acalypha brachiata</i> <i>Krauss</i>	Euphorbiaceae	<i>Mulyatangombe</i>	IKSTF0548	One month
<i>Momordica balsamina</i>	Cucurbitaceae	<i>Karuweruwe</i>	IKSTF0568	Two weeks
<i>Asparagus nelsii</i>	Asparagaceae	<i>Kayanambo</i>	IKSTF0514	3 months
<i>Capparis tomentosa</i>	Capparaceae	<i>Mulyangwe</i>	IKSTF0537	2-3 days
<i>Baikiaea plurijuga</i>	Fabaceae	<i>Ghughaha</i>	IKSPS0534	One year
<i>Euclea divinorum</i>	Ebenaceae	<i>Mpumutji</i>	IKSTF0536	One year
<i>Pterocarpus angolensis</i>	Fabaceae	<i>Ghughuva</i>	IKSTF0543	One year
<i>Albizia tanganyicensis</i>	Fabaceae	<i>Mupako</i>	IKSTF0541	One day
<i>Commiphora africana</i>	Burseraceae	<i>Mughogho</i>	IKSTF0531	3-4 days
<i>Dichapetalum cymosum</i>	Dichapetalaceae	<i>Namuthata</i>	IKSTF0526	One day
<i>Guibourtia coleosperma</i>	Fabaceae	<i>Ghushivi</i>	IKSTF0521	One day
<i>Ochna pulchra</i>	Ochnaceae	<i>Ghushika</i>	IKSTF0569	Two weeks
<i>Salacia luebbertii</i>	Celastraceae	<i>Muna /Katughuru</i>	IKSTF0558	One week
<i>Pterocarpus lucens</i>	Fabaceae	<i>Ghupako</i>	IKSTF0559	Three weeks
<i>Diospyros mespiliformis</i>	Ebenaceae	<i>Mutunda</i>	IKSTF0561	Four weeks
<i>Chenopodium pumilio</i>	Chenopodiaceae	<i>Mukwengo</i>	IKSTF0562	One weeks
<i>Dichapetalum rhodesicum</i>	Dichapetalaceae	<i>Mukweyu</i>	IKSTF0564	Three weeks

The plants in Table 3 were used by the traditional healers, at different levels, to treat the three common mental disorders. They produced different therapeutic effects on the *muveri* (sick person). As indicated in the introduction, medicinal plants have therapeutic power/s which need to be “enticed or seduced” by the traditional healers to produce a transformative effect on the

muveri (sick person). Many of the traditional healers indicated to me that medicinal plants (*mutondo*) have healing or spiritual power/s. Kasenge explained:

Karunganyambi (God) is the one who has created people and people are faced with many challenges including illness. Therefore, God has also created plants which people can use for so many things such as prevention of misfortunes like lightning strike, but importantly as medicine (*mutondo*). Therefore, my son we have a saying that heal with God so that the Ancestors can hear you (*Kupanga naNyambi hathimu ghakuyuve*).

Traditional healers grow some medicinal plants in their yards but most of the plants are collected along the river or inland a few kilometres from the homestead. Healers like Kasenge view plants as living organisms with healing powers from the ancestors (*vadimu*) and God (*nyambi/karungu*). Central to the narrative above is the power of medicinal plants that needs to be evoked through the ancestors and God (*nyambi/karungu*).

The ancestors were consulted through the divination device, the *katemba*, to guide healers in their selection of plants. With the blessings of the ancestors, traditional healers sent the *tungangwena* (trainees) to collect the plants. While harvesting plants the *tungangwena* were under the protection of the spirit of the ancestors (*vadimu*) - who guided them and protected them from dangerous animals of the wild. When I accompanied the *tungangwena* to collect the plants I carefully followed in their footsteps for protection and safety. While in the field I was taught techniques for interacting with the plants which are seen as living organisms and part of nature (*ntjitwe*). For instance, when the *tungangwena* gave me the plants I had to take the end of the plant offered to me and give it a quick pull while the *tungangwena* would tug in the opposite direction, before releasing the plant: like a plant itself would 'hold on' for a moment before it is pulled from the earth or releases a branch. No exchange of words takes place at this moment, but it is a form of communication which symbolizes that the plant is collected in a peaceful manner, that it is alive and is highly valued or respected, that it releases itself and its potential to the person who collects it.

Traditional healers also speak to the plants during healing ceremonies as demonstrated in Chapter 5. Plants need to be collected and handled with care so that their healing power is

preserved or stored, and can be transferred to the sick person during the administration or healing ceremony to produce therapeutic effects. Nonetheless, plants still need to be persuaded or seduced by the traditional healers to produce the therapeutic effect discussed in the next sections.

6.4 Therapeutic powers of medicinal plants on mental illness

Since time immemorial, mankind has used plant extracts from different plants to cure diseases and bring relief from physical agony (Taid et al 2014, p.6).

Petrovska (2012, p.56) noted that people have always searched for medicinal plants in nature, and argued that the origins of the use of medicinal plants were driven by the instinctive human struggle against illness. As shown in Figures 3 and 4 above, traditional healers make use of plants and their extracts therapeutically and plants continue to play an essential role in health care. I argue that the plants' therapeutic powers need to be 'enticed' by the traditional healers. These transformative abilities of plants, their healing essence, liveliness and energy are linked or entangled with humans through the movement of air, breath and wind between them and brings about change (and healing) across space and even time (Gibson 2010, p.56; Low, 2009). A medicinal plant can be picked in one place and at a certain time and utilized at another time and in a different setting: its aroma, vitality and ability to heal can be released elsewhere if it is handled properly.

During my stay with traditional healers I observed a number of *muveri* (sick persons) with mild to severe mentally related disorders being treated with medicinal plants. The medicinal plants were central to the management of mental illness, since they were widely utilised for ritual ceremonies, as well as administered to the *muveri* (sick persons) in different forms⁵⁰. Plants were used everywhere, as an omnipresent source of therapeutic powers evoked by the traditional healers: through respectful harvesting, rituals, talking to the plants and calling on the ancestors to entice the former's healing potential to benefit the *muveri*.

⁵⁰ see 6.4 below

I argue that the visibility of medicinal plants in the healing process had a symbolic meaning as well: it gave the sick person and family members the assurance that the illness was being treated. The plants also had a psycho-physiological effect: it produced a particular smell which was believed to chase away bad spirits as well as providing protection to the sick person. When plants were used on the sick person's body, ingested or inhaled, they acted as agents of power that gave rise to the hope of curing or removing the illness from the afflicted person. It seemed that the power of plants had to be 'released' by the traditional healers, drawing on their broader spectrum of local healing methods. The plants' aroma drew the attention of the ancestors. When administered, the plants had healing effects, but also served to spiritually protect the afflicted. Thus traditional healing was comprehensive in that it not only focused on the curative process but included protective and preventive elements.

As shown in Chapter 5, traditional healers view some illnesses as natural and others as supernatural phenomena governed by a hierarchy of vital powers beginning with the most powerful deity, followed by lesser spiritual entities, ancestral spirits and living persons (Truter 2007, 57). As such, medicinal plants are not only used to treat the illness but also to manage the interactions between the spiritual and physical well-being of the sick persons (ibid). I argue therefore that plants not only possess medicinal value, they also have transformative abilities to cure, protect from or prevent illness. Thus, for healers the power of medicinal plants is constituted through accepted forms of local healing operating on a different level from other forms of healing. During my research I observed the transformative power of medicinal plants. For instance, while plants possess therapeutic power in their habitat (which is anywhere in the region) that ability was not actually visible to the lay person: although the plant's presence symbolized healing potential. The therapeutic potential of the plant had to be triggered by the traditional healers - through e.g. the way in which it is collected and prepared, where it is collected, how it is administered, the rituals accompanying or prefacing this process etc - for the purpose of treating a particular ailment or illness.

There were individuals, especially the elderly, who knew the value of certain plants and used them personally or for their families. If their home treatment did not succeed, traditional healers were approached to evoke the medicinal plants' 'meta-power' - e.g. through rituals and

communicating with the ancestors, - to produce a therapeutic effect on the sick person. Although this could easily be interpreted as a placebo effect, studies nonetheless show that a placebo can induce a real biological effect triggered by any number of stimuli, including conditioning, expectancy, therapeutic relationship, and andsociocultural meaning (Thompson et al 2009, p.15). Furthermore, stimuli may act through any number of biological pathways: some identified and others still unknown (Thompson et al 2009, p.15).

The transformative power of plants were activated by boiling, powdering, crushing and soaking, among others, as a way of increasing their rate of reaction to produce more therapeutic power. Many scholars working with plants mention this power and agentivity of medicinal plants (Rival and McKey 2008, p.12; Riva and McKey, 2008). Consequently, plants are no longer only seen as material used in the traditional healing but rather as living organisms that are able to breathe, live, reproduce, feed, poison, defend against, or even hide themselves from predators (Gibson 2010, p.57).

Traditional healers in Kavango have a somewhat similar understanding of the power of plants – they see them as living entities in nature with therapeutic power which could be activated as part of their traditional healing - since God, through the ancestors, had made such plants available and they can be ‘activated’ inter alia through the *katemba* (divination device). Importantly, a plant comes from nature, where there is constant movement, so their potentiality intermingles with the wind, air, people and animals.

Cohen, who studied *kruiedokters* (herbal doctors), alluded to the power of medicinal plants and used the Afrikaans term *krag* (Cohen 2015, p.20) - which can be loosely translated to mean power, vitality, or strength. *Krag* is a kind of ‘body energy’ that waxes and wanes with the ups and downs of everyday life (Ibid, p.20). Cohen explained that while *bossiemedisyne* (bush medicine) or medicinal plants were used by patients to regain health and their strength, other forms of healing (such as jokes, guitar playing and food) were also used as catalysts to alleviate various illnesses, including high blood pressure, diabetes, colds and flu, and swelling in the limbs, among others (Green et al 2015, p.7). Importantly Cohen (2015, p.21) takes note of the power of medicinal plants:

The *krag* (power, vitality, or strength) is in the plants themselves, which enables them to do their healing work, (and) is closely associated with the *krag van die natuur* (the power of nature), this in turn being closely associated with *die Here* (the Lord).

Cohen's conceptualization of the power of medicinal plants among *kruiedokters*, which he relates to nature and God, is similar to the Kavango traditional healer's version mentioned earlier in the chapter: the term used is "Heal with God so that the ancestors can hear you (*Kupanga naNyambi hathimu ghakuyuve*)".

From the above there is a clear link between the power of medicinal plants in the plant itself - as in Cohen's argument, attaching that power to both nature and God. While medicinal plants possess the power to heal the sick or chase away bad spirits, I surmise that that power needs to be tapped into, or teased out, to produce a therapeutic effect on a person- and I would argue that traditional healers possess such knowledge and ability. Therefore, through their ritual ceremonies and administrations of the plants to sick persons, the power of medicinal plants has a real effect on sufferers. In traditional healing in Kavango the reality of experiencing the power of medicinal plants is located in nature, ancestors and God. Thus, people who were identified as suffering from mental illness are treated with medicinal plants but the success of such treatment is embedded also in the skill of the healer to 'activate' it, the power of the ancestors and of God (*Nyambi/Karunga*).

I noted earlier that traditional healers in Kavango locally diagnose sick persons into three categories namely; *nyambi*, *kasenge* and *ndjangura* (see Chapter 5 on these local classifications of mental illness). The treatment provided by traditional healers seemed more successful in these cases of what Goldberg and Huxley (1992) referred to as 'common mental disorders' (CMD), i.e. those principally encountered in community settings. All those treated by the traditional healers were brought to them by the sick person's family members.

Following diagnosis the traditional healers would begin treatment, always with the *kudjamba*

ritual ceremony after sunset⁵¹. Following the ritual ceremony the sick person was treated with various healing methods namely (1) *kufuka* (to cover/steaming with decoction or infusion), (2) *kudima* (splashing and bathing), (3) *Kuyoteka* (inhalation), (4) *kurukita* (induced vomiting), (5) *kuhupira* (induced diarrhea), (6) *kushotja* (eye and ear drops) and (7) the drinking of a decoction or infusion. (See Figure 6 below) The most common route of administration was oral (12 citations), followed by steaming (8 citations) for the medicinal plants prescriptions. Other routes of administration were based on combined approaches such as oral and steaming (7 citations) and oral and eye drops.

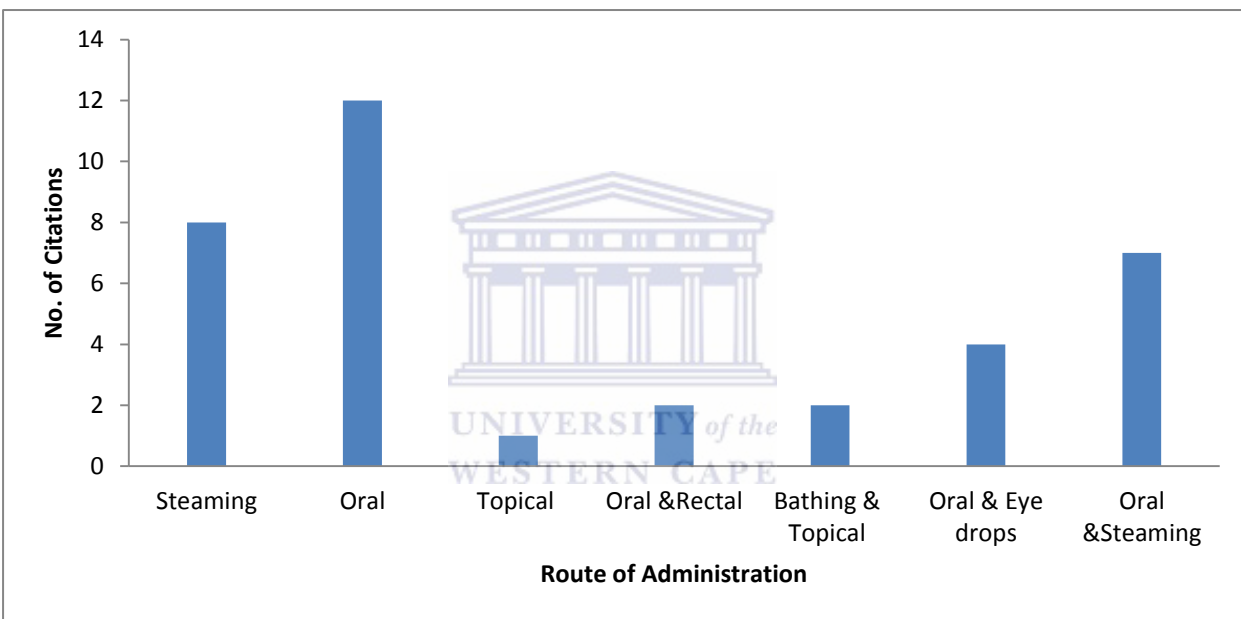


Figure 12 Route of administration of medicinal plants used by traditional healers in Kavango regions

6.5 Plants at work: administration and healing methods using medicinal plants

6.5.1 *Kufuka* (to cover/steaming with decoction or infusion) and *kudima* (splashing and bathing)

Once the traditional healer has determined the diagnosis through the *katemba* (divination

⁵¹Vide chapter 5 on this ritual ceremony.

device) - for all the three common mentally related illnesses (*kasenge*, *nyambi* and *ndjangura* illness) - the sick persons (*muveri*) underwent a healing journey, which could involve ingesting, steaming, washing (or both) or sprinkling with medicinal plants. During the treatment the mentally ill person was covered with a blanket, sitting over a heated pot containing medicinal plants. The roots and leaves of the following medicinal plants were usually placed in the pot; (1) *mulyavambi* (*Pseudolachnostylis maprouneifolia*) (2) *kayanambo* (*Asparagus nelsii*) and (3) *nyambi* (*Diospyros virgate*). These plants were believed to fulfill different functions in the treatment and healing process of the sick (*muveri*). As Kaghonda, a junior traditional healer, explained while we were collecting *Kayanambo* (*Asparagus nelsii*) in the field:

Maika, here is *kayanambo* the plant that we normally use to chase bad spirits (*varodi* and *vadimu*)⁵².” I went closer to him to see it and touched the plant’s leaves. “Here, smell it,” said Kaghonda, “this plant is significant in the treatment of mental illness because as long as the bad spirits are present, the *muveri* (sick person) will not get well. You see Maika, we boil these leaves and roots⁵³ in a pot and cover the person so that the medication can go into the body and the strong smell chases away the *varodi* (witches).

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I observed that after the patient had been ‘steamed’ the traditional healer would usually end the treatment by splashing or sprinkling the rest of the hot, plant-infused water on the sick person, using a tail of a cow⁵⁴. I attended these sessions - they normally happened after sunset or early in the morning before sunrise, at the homestead of the traditional healer or in the bush⁵⁵. Only family members were allowed to attend the ritual, for privacy and confidential purposes. During the ritual of *kudima* some of the water was splashed on the family members, and at times on me⁵⁶. Thus, Both *kufuka* (to cover/ steaming with decoction or infusion) and *kudima* (to splash and bathe) treatment are believed to protect the patient against the *varodi* (witches)

⁵².*Varodi* are the witches and *vadimu* in this case referred to the angry ancestors

⁵³ Kaghonda warned me that the roots should be boiled with a lot of water for an hour before they were ready to be used for the ritual. The roots are believed to be poisonous if not administered correctly.

⁵⁴ This process is locally known as *kudima*

⁵⁵ I only attended the ritual sessions that were done at the traditional healers place, because the one that are conducted in the bush usually can raise suspicion of witchcraft activities among the locals so I avoided such sessions.

⁵⁶ The water was always hot and had a very strong, tenacious smell from the medicinal plants. Whenever I attended such rituals I tried to take a shower before I met with people who had not been involved with the ritual.

and *vadimu* (angry ancestors). Kaghonda told me that if a person goes through this process neither the *varodi* (witches) nor *vadimu* (angry ancestors) will attack the person again.

6.5.2 *Kuyoteka* (inhalation), *kurukita* (induced vomiting) and *kuhupira* (induced diarrhea)

Two medicinal plants namely *mutengura* (*Swartzia madagascariensis*)⁵⁷ and *mpindu* (*Ancylanthos rubiginosus*)⁵⁸ were used for inhalation and to induce vomiting respectively. *Uguni* (*Strychnos spinosa*) was used for *kuhupira* (induced diarrhea). In this regard, *mutengura* (*Swartzia madagascariensis*) was utilised for inhalation to treat *kasenge* and *ndjangura* illness – especially when the *muveri* (sick persons) were aggressive. *Mpindu* (*Ancylanthos rubiginosus*) was mainly used to treat mood-related disorders for *nyambi* illness – e.g. when the *muveri* (sick persons) refused to speak. The plant was responsible for alleviating the mood of such a person. I also observed that, in some cases, *mpindu* (*Ancylanthos rubiginosus*) was used as an antidote – e.g. when a *muveri* (sick persons) had been over-sedated with *mutengura* (*Swartzia madagascariensis*). The latter was used as a sedative to calm mentally ill persons who presented with aggressive behavior. I observed that mentally ill persons who were given this plant were not only calmed but eventually fell asleep. Nawandambu, a senior female traditional healer, explained:

If a person is suffering from *nyambi*, besides the drum healing ceremony the person should also be treated with a medicinal plant by the name of *mutengura* through *kuyoteka* (inhalation) healing method. You take the leaves and roots of *mutengura* and burn them on the fire. Then the *nyambi muveri* should sit around the fire to inhale the smoke from the medicinal plants: in the process the illness in the chest will be

⁵⁷ *Mutengura* (*Swartzia madagascariensis*) acted as a sedative usually after the treatment the patient will be calm and eventually fall asleep. The plants were used for aggressive patients. But I noticed that the *Mutengura palnt* is also well known among women, who used it to control their cheating husbands by putting the plants in their food. It is believed that the medicine prevents the husband from taking interest in other women and such a man can only act on the instructions of his wife. When I asked women about the plant some of them broke into laughter, but confirmed the usage of the plants on men.

⁵⁸ *Mpindu* (*Ancylanthos rubiginosus*) was mainly used to treat mood disorders for *nyambi* patients who refused to talk to anyone, to alleviate the mood of such a person. In some cases it was also used as an antidote in patients who were over-sedated with *mutengura*. Such patients were given *mpindu* so that they could become active again. Both *mutengura* and *mpindu* were believed to stimulate hunger, so family members were advised to have food ready for the patients.

demolished.

Lucia Shashipampo (female senior traditional healer) believed that *kurukita* (induced vomiting) was the key in treating *kasenge*:

If a person is suffering from *kasenge* it important to give such a person the medicinal plant by the name of *uguni* (*Strychnos spinosa*) to drink, so that a person can vomit in order to remove the illness or the foreign object from the chest: *kasenge* appears when a witch gives his/her victim something to eat (usually meat) while he/she is asleep. Therefore, such a person needs to be saved by inducing vomiting so that the foreign object can be removed from the body. However, at times the foreign object can be in the stomach and the *katemba* (divination device/oracle) will pick it up: then the medication should be given via the anus: the process known as *kuhupira* (induced diarrhea)” she laughed, “... my son I am not insulting you but that is what we do here. But we do not do it here in the house, no. You have to take the person in the bushes in the early hours before everyone wakes up.

I observed that rituals were prominent in the treatment of mental illness in Kavango. Truter (2007, p.59) pointed out that in many African communities, if the cause of the sickness is perceived to be bewitchment, a number of rituals may be performed in order to cast out the spell. These may include the induction of vomiting, enemas, blood-letting, whistling or elaborate rituals such as animal sacrifices (Truter 2007, p 59). Truter (Ibid) explained that rituals play an important role since many Africans believe that if the ancestors withdraw their protection and gift of good fortune, the descendant is left vulnerable to all sorts of misfortunes and diseases. The wrath of the ancestors is usually evoked by discord in the home, the violation of customs and traditions or non-observance of certain taboos, therefore traditional medicine’s rituals aim to restore balance and harmony in terms of the beliefs and values of culture. Truter (Ibid) concluded that rituals reduce patients’ anxiety, serve to relieve feelings of guilt and often produce a calming effect on the patient.

6.5.3 *Kushotja* (eye and ear drops)

One of the healing methods used in the treatment of mental illness was the administration of medication as eye or ear drops, known among the *vanganga* as *kushotja*. The fresh leaves for plants such as *mpumutji* (*Euclea divinorum*) and *namuthata* (*Dichapetalum cymosum*) were boiled and the liquid extract from these plants was used as eye or ear drops. The *vanganga* believe that a mentally ill person screams and says things which do not make sense because they see and hear the ghost or person bewitching them. Eye and ear drops protect the mentally ill person from the ghost and the witch. However, George Mukoya, a male healer, had a different version;

Sometimes the madness can run into the eyes of a person, and that is why they scream, run around and say all kind of things, which is why we give the medications in the eyes of a person.

In other instances administration via the eye and ear was pursued if the sick person refused to drink the medications. Healer Lucia Shashipampo believed that the medication (*mutondo*) could be more easily be absorbed by the body, compared to other healing methods. However, she warned about the risk of overdosing the person and cautioned that this method should only be utilised by an experienced person, or under supervision.

It was quite fascinating to observe that traditional healers never administered these plants on their own, but rather in combination with other plants as a cocktail or mixture. The above medicinal plants were also used differently by different healers for the same condition. Cocktails given to the patient contained the following medicinal plants, mostly (1) *mulyavambi* (*Pseudolachnostylis maprounefolia*) (2) *kayanambo* (*Asparagus nelsii*) (3) *nyambi* (*Diospyros virgate*) (4) *mutengura* (*Swartzia madagascariensis*) and (5) *mpindu* (*Ancylanthos rubiginosus*). Table 4 below sets out the plant part used, stating mode and route of administration, including and the estimated time of recovery as observed or narrated to me by the healers.



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Table 4 Top five medicinal plants prescribed by the traditional healers in Kavango Region to treat mental illness.

No.	Plant name	Scientific name	Collection no.	Plant parts	state of use	Mode of prep.	Direction of use	Time recovery
1	Mulyavambi	<i>Pseudolachnostylis maprouneifolia</i>	IKSTF 546	Roots & Leaves	Dry & Fresh	Boiling	Oral	One week
2.	Kayanambo	<i>Asparagus nelsii</i>	IKSTF0514	Roots & Leaves	Fresh & Dry	Boiling	Steam	Three months
3.	Nyambi	<i>Diospyros virgate</i>	IKSTF0544	Roots & Leaves	Fresh & Dry	Boiling	Oral & Eye Drops	Two days
4.	Mutengura	<i>Swartzia madagascariensis</i>	UNME228	Roots & Leaves	Fresh & Dry	Boiling	Oral & Steaming	One month
5.	Mpindu	<i>Ancylanthos rubiginosus</i>	IKSTF0552	Leaves	Fresh	boiling	Oral	One week

6.6 Social stigma of mentally ill persons

Stigma is not a new phenomenon in relation to mental illness. Goffman (1963) defined stigma as a mark that set a person apart and reduced him or her from a whole person to one tainted or 'spoiled'. Goffman noted the way stigma is "marked" as something easily visible or simply suspected: either way, it has major effects. It became clear to me that mentally ill persons were handled and treated differently from the rest of the *muveri* (sick persons). Those suffering from *ndjangura* and *kasenge* - who presented with aggressive behavior - were isolated and tied to a tree in the yard during the day. At night they were tied to a pole of the thatch house. The idea was supposedly not to harm them but rather to prevent them from harming others, or themselves. At times they were heavily dosed with *mutengura* (*Swartzia madagascariensis*) especially at night to prevent them from making too much noise, so that other *muveri* (sick persons) could sleep. Family members were responsible for the care of the mentally ill persons while they were at the traditional healer's place. Family members provided food and clothing and infrequently washed the mentally ill. Junior traditional healers mostly visited the sick persons when giving medication (*mutondo*) or if alerted by a family member about any urgent need. The caregiver-sick person relation improved for the mentally ill persons who made progress and who could be re-integrated into society. For those whose condition remained the same or worsened, nothing changed. In fact some family members complained that they were tired of looking after them.

Kleinman, (2009, p.606) noted that the lack of mental health interventions in many countries left families and social networks unprepared to care for the mentally ill. Kleinman warned about the stigma of mental ill persons: firstly, that the poor conditions of care provided without professional support could amplify the stigma of mental illness and secondly, the social and financial burden of care could exacerbate the mistreatment of the mentally ill within families. In Kavango - where mental health care facilities are non-existent - traditional healers became the only hope for the mentally ill and their family members. Thus, family members are constantly faced with the severe financial burden of looking after the mentally ill, and at times they might neglect or mistreat them. In some cases family members gave up on severely mentally ill persons and they were neither taken to the traditional healers nor to the hospital. They could be

seen roaming around in filthy clothes, naked or half naked, neglected and avoided.

During my fieldwork there were three men in different villages who were in the above condition. The first one was at Kangweru village, a young man in his mid-thirties, a former soldier who had been relieved of his duties due to mental illness. I learned that he had been diagnosed with schizophrenia and received his monthly antipsychotic injection at the hospital, in Rundu. During the day he roamed around in extremely dirty and ragged clothes, incomprehensibly talking to himself. He no longer had friends and family avoided him. The second case was at Mamono village. He was in his forties and was not being treated - either at the hospital or by the traditional healers. The third case was at Mbwata village where the senior traditional healer by the name of Shamwaka lives. This man, also in his forties, walked around the village, talking to himself incessantly. He was not receiving any treatment. These people were avoided and not allowed to attend social events such as weddings, funerals, or when others met. They are seen as mad, or abnormal, and unable to participate in normal society. They were rejected, either consciously or unconsciously. Nobody seemed to care much, because their mental illness was seen as chronic and there was nothing that could be done for them⁵⁹.

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Such persistent, active avoidance, abandonment, or even imprisonment in institutions or homes for the mentally ill is what Guo and Kleinman (2011) refers to as social death. In this regard, they highlighted the Chinese notions of personhood which requires that individuals fulfill social obligations, “save face” and exhibit self-control, in order to be considered fully human. Therefore, those who cannot fulfill these requirements belong nowhere; they are ignored, humiliated, and treated as non-persons (Guo and Kleinman 2011; Zhang and Daum 2013; Lee et al. 2006). In this context the stigma of mental illness is worse than other stigmas since the mentally ill persons are socially excluded from ordinary life, lose their protection and become rejected by their local worlds, the state, and even institutions like aid organizations and religious groups (Zhang and Daum 2013).

6.7 Conclusion

In this chapter I have discussed traditional healing of mental illness with a particular focus on medicinal plants as treatment. I have argued that medicinal plants have therapeutic powers which need to be “seduced” by the traditional healers to have the healing effect on the sick person (*muveri*). I further argued that plants are not only seen as material used in the traditional healing but rather as living organisms with their own abilities (Gibson 2010, p.57). In addition the chapter also discussed how medicinal plants were used by traditional healers in treating the three common mental disorders namely; *ndjangura*, *kasenge* and *nyambi*. These local categories or classifications of mental illness can also be referred to as “culture-bound syndromes” (DSMIV, 1994; Littlewood and Lipsedge, 1989).

Although there is little evidence to support the efficacy of the medicinal plants (Swartz (1996, 153) which I have discussed, local communities draw on both biomedical and traditional taxonomies and treatments in order to address mental illness (Long and Zietkiewicz 1998,p. 15). Therefore, it is imperative that indigenous healing in mental health be seriously considered in terms of collaboration between the biomedical and the traditional, for the benefit of all. An understanding of local perspectives of common mental disorders will allow biomedicine to provide culturally sensitive and locally acceptable health care. At present collaboration between biomedicine and traditional healing in Namibia is still in its infancy but there is little effort from the government to guide this. In this regard, the Mental Health Policy document in Namibia of 2005 is notably silent on the issue of traditional healing while the status of the Traditional Health Bill also hangs in the air (New Era 2004).

CHAPTER SEVEN

7 GENERAL CONCLUSION

This chapter summarises and draws together the main points that have emerged from this thesis. In addition it also touch briefly on some areas in which research might be taken forward in the future. My first encounter with anthropological perspective on mental illness was during the course of my MA in medical anthropology in 2009. As part of the structured course work at the time we were introduced to both anthropological and sociological theories on mental illness. Nonetheless, at that stage I did not take much interest in anthropological theories on mental illness given my nursing background - I had been trained in a biomedical model which often presents psychiatry as a hegemonic worldwide system (Watters 2011). However, for the purposes of my doctorate, I had to engage with mental illness from the viewpoint for medical anthropology.

The main aim of this thesis was to explore the social and cultural construction of mental illness from the traditional healers' perspective in Kavango. As such, the study examined mental illness within the realm of expertise that of *vanganga* (traditional healers) and explored the various local aetiologies and treatment as well as the social and cultural meaning of these illnesses. In particular the thesis discussed 'local' notions of mental illnesses and treatment (including medicinal plants) in Kavango. I focused on three local, commonly diagnosed, illness categories used by the *vavanga* themselves, namely; (1) *nyambi* (2) *kasenge* and (3) *ndjangura*. These are specific to Kavango people - and based in their local cultural setting - (DSMIV, 1994; Littlewood & Lipsedge, 1989) yet they are not discrete categories. They do differ in terms of manifestation and underlying assumptions, explanations and treatment (Long and Zietkiewicz 1997, p. 7).

While traditional healers view these local notions of mental illness as static, in reality they are active and vary over time (see Foucault, 1967). They are also being reproduced, evolve and can be idiosyncratic and context dependent (Ventevogel et al 2013, p. 2). By presenting traditional healers' local constructions of mental illness I do not view their aetiologies as rigid - given the

changing nature of our social world and the efforts of individuals to adapt to these changes. I thus view these local notions as an ongoing process or work in progress. The *vanganga* in Kavango construct mental illness through their diagnostic methods, operate from the point of view of traditional healing systems and use spiritual forces as a mode of communication with the ancestors through the *katemba* (divination device). In this way they determine the cause of, and identify, the illness. Within these systems, mental illness is frequently seen as a sign that the family has deviated from cultural norms, as a form of harm instigated by a jealous person or as a physical problem (Teuton et al 2007, p. 1262).

Thus the thesis argues that while traditional healers view mental illness as a physical ailment that causes disruption of mind/head/brain they also understand it is as a possible result of social deviance, ancestral wrath or witchcraft. Accordingly, traditional healer's therapeutic action aims not only to treat, and preferably cure, the sufferers, but also to restore the social order disrupted by the angry ancestors or witches. In this regard, the *vanganga* (traditional healers) restore the social order at family level through the *kutjamba* ritual ceremony, and at the community level, through the *kuvetera ngoma* (drum ritual ceremony). Unlike most studies in which mental illness has been constituted as highly individual, personal and private (Swartz 1996), the *vanganga's* explanation of mental illness includes components of social and psychological approaches which provide meaning for the mentally ill persons and their families (Teuton et al 2007, p. 1262).

The understanding of local notion of mental illness by traditional healers which came out of this thesis can make a significant contribution to the study of mental illness in cross cultural settings which can be used to influence mental health policy to improve the health of the people in Namibia and Kavango in particular where mental health care are almost non-existent at the moment. As I have stated in my introduction remarks that the study is situated against the background of the World health organization's 2005 statement of "No health without mental health" (WHO 2005). Thus, this study is a response to this call for the improvement of mental health globally: a prioritised area of study, research and practice aimed achieving equity in health worldwide (Kohrt and Mendenhall 2015, p. 37). In order to achieve these goals various disciplines should come together to facilitate the development and implementation of

appropriate mental health policies which are sensible to contextual factors such social and cultural factors among others.

As I have shown throughout thesis, psychiatry and traditional healing are both important to deliver health service in non-stigmatizing, culturally compelling manner to achieve the vision of mental health for all (Kohrt and Mendenhall 2015, p. 37). Being knowledgeable about local understandings and treatment of mental illness can also be useful to health care workers - in identifying local way of expressing distress and as avenues to identify potential individuals in need of psychological and ultimately provide mental health services. To conclude this section on local notion of mental illness I strongly argue in this thesis that mental illness cannot be isolated from the context in which it occurs - instead potential interventions could be multiple- e.g. psychiatric services, as well as traditional healers.

The thesis also discussed various categories of traditional healers in Kavango, their diagnostic process as well as their current lack of legal status. I argued that the current classification of traditional healers into the broader categories of herbalist, diviner, and medium-diviner makes it difficult to distinguish between them. I provided a new way of refining the classification of traditional healers in Kavango, thereby including levels of training and knowledge but also the area of speciality.

Despite various calls for the recognition and regulation of traditional healers and medicines in Kavango, this issue has remains contentious and ineffective (Rautenbach 2008, p. 2). The thesis thus argued that there is urgent need to utilize traditional healers as part of the health care team in order to address the daunting and rapidly growing burden of mental illness - which is currently not met by the official health care system, and to help bridge the cultural gap in the conceptual appreciation of health and illness.

I explored medicinal plants and their application by traditional healers to treat various mental illnesses. I argued that medicinal plants possess powers that need to be “enticed or seduced” by healers in order to produce a therapeutic effect on the *muveri* (sick person). I contend that medicinal plants are perceived to have transformative abilities that can affect the people who

utilize them (Hsu and Harris, 2012, p. 24). I can, however, not speak to the pharmacological make-up of the medicinal plants used.

7.1 Some recommendation for future research on mental illness in Kavango and Namibia in general

My first recommendation on the integration of traditional healers into primary health care, as I have argued that traditional healers in Kavango provide basis health care to the people by using medicinal plants and ritual performance not only for mental illness but for other health problems as well. Therefore, there is a need to recognise, regulate and empower them via training and resources to improve health care for the people as per WHO call since 1978.

Secondly, there is a urgent need for a strong political will to speed up the traditional healers bill so that is be passed to facilitate the registration and regulation of traditional healer in Namibia. Thirdly, although my focus for this thesis was on traditional healers, medicinal plants and mental illness I highly recommend that government should consider building a psychiatric hospital in Kavango since a lot of them still do not have access to biomedicine and psychiatric services are non-existent which a barrier in elevating mental health in the region.

I end with a quote from Sir Isaac Newton which state that **“I can calculate the motions of the heavens, but not the madness of men.”**

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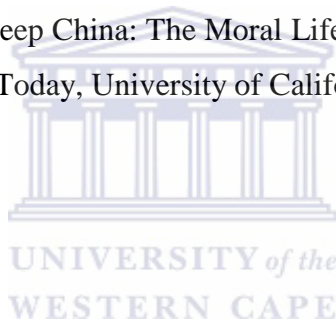
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APPENDICES

APPENDIX 1: Information sheet

UNIVERSITY OF THE WESTERN CAPE

DEPARTMENT OF ANTHROPOLOGY AND SOCIOLOGY

Private Bag X17, Bellville, 7535, Cape Town, South Africa

Tel: (021) 959-2336; Fax: (021) 959-2830

November 2013

Title: The use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.

Researcher: Michael Shirungu

You are invited to participate in a study on the use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia by Michael Shirungu under the supervision of Prof Diana Gibson at the University of the Western Cape, Anthropology/Sociology department. The information will be used to write a PhD dissertation and (with your permission) publish the results. Participation in this study is voluntary. With your permission, our conversations will be recorded and data will be used for publication. If you wish, pseudonyms will be used. If you would like to see the information about yourself and/or what you said at any time, you can do so. I will keep your identity strictly confidential. You may withdraw from this study whenever you wish, and if you do, all information you provided will be discarded. Your withdrawal from the study will in no way affect your access to or the use of traditional plant medicines or pharmaceuticals. If you agree to participate in this study, you will be asked to sign a consent and access and benefit sharing agreement which will protect and inform you of your rights as a participant.

Thank you for taking the time to read this leaflet. If you are unclear about anything or need further information, feel free to contact us at:

Researcher: Michael Shirungu 0812355093

Supervisor: Prof Diana Gibson: (021) 959 3349



UNIVERSITY of the
WESTERN CAPE

APPENDIX 2: Informed consent

UNIVERSITY OF THE WESTERN CAPE: DEPARTMENT ANTHROPOLOGY AND SOCIOLOGY. Private Bag X17, Bellville, 7535, Cape Town, South Africa Tel: (021) 959-2336; Fax: (021) 959-2830

November 2013

Title: The use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.

I... have been explained in the language that I understand about the nature and purpose of the study. Therefore, I am participating in the study on my own will and I can withdraw from the study at any time I wish to. The researcher has explained to me that this information will be treated as confidential and my name will be anonymous. I

Understand that the information will be used for academic purposes.

I therefore I give my consent to take part in this study.

Participant's signature

Date.....

For any enquiries regarding the study or wish to report any problems you have experienced related to the study, please contact the principal researcher: Mr. Michael Shirungu

University of the Western Cape

Private Bag X17, Belville 7535

Cell phone Number (SA) 85 +2279 234 1932

Cell phone Number (Nam) 86 +264 2355 093

Supervisor: Prof. Diana Gibson (021) 959 3349 Fax: (021) 959-3686

APPENDIX 3: Access and benefit sharing agreement

UNIVERSITY OF THE WESTERN CAPE: DEPARTMENT OF ANTHROPOLOGY AND SOCIOLOGY

Private Bag X17, Bellville, 7535, Cape Town, South Africa

Tel: (021) 959-2336; Fax: (021) 959-2830

November 2013

Title: The use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.

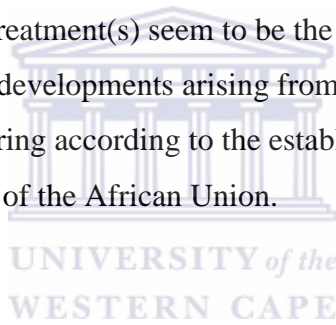
In response to the **recipient's** (researcher) request for the **material** (plants), the **provider** should understand and agree to:

1. The above material is the property of the provider and is made available as a service to the research community.
2. The material will be used for teaching or not-for – profit research purposes only.
3. The material will only be made available to other researchers with the approval of the provider.
4. Any material delivered pursuant to this agreement is understood to be experimental in nature and may have hazardous properties. The provider makes no representations and extends no warranties of any kind, either expressed or implied. There are no express or implied warranties of merchantability or fitness for a particular purpose, or that the use of the material will not infringe any patent, copyright, trademark, or other propriety rights.
5. Unless prohibited by law recipient assumes all liability for claims and for damages against it by third parties which may arise from the use, storage or disposal of the material except that, to the extent permitted by law, the provider shall be liable to the recipient when damage is caused by the gross negligence or wilful misconduct of the provider.

6. The recipient agrees to use the material in compliance with all applicable statutes and regulations.
7. The material is provided at no cost, or with an optional transmittal fee solely to reimburse the provider for its preparation and distribution costs.
8. Each party are to receive a signed copy of this agreement upon which the provider will transfer the material.

Benefit sharing:

1. The researchers endeavours not to give false hopes or make promises which cannot be fulfilled.
2. The researchers will share of results of this research, so that the whole community is informed regarding which treatment(s) seem to be the most effective.
3. In the event of commercial developments arising from this research, the researchers agree to a principle of benefit sharing according to the established principles of South African law and relevant guidelines of the African Union.



Provider information:

Name.....Surname.....
 Id number.....Sign.....
 Place of transfer.....

Recipient's details

Name.....Surname.....
 Id number.....Sign.....
 Place of transfer.....

Researcher: Michael Shirungu
 Cell phone Number (Nam) 86 +264 2355 093/
 (SA) 85 +2279 234 1932
 Supervisor: Prof Diana Gibson: (021) 959 3349

APPENDIX 4: Informed consent for audio recording

UNIVERSITY OF THE WESTERN CAPE: DEPARTMENT ANTHROPOLOGY AND SOCIOLOGY. Private Bag X17, Bellville, 7535, Cape Town, South Africa Tel: (021) 959-2336; Fax: (021) 959-2830

Title: The use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.

You are invited to participate in a study on **the use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.** With your permission, our conversations will be audio recorded and data will be used for documentation, research, and publication. If you wish, pseudonyms will be used. If you would like to see the information about yourself and/or what you said at any time, you can do so. I will keep your identity strictly confidential. You may withdraw from this study whenever you wish, and if you do, all information you provided will be discarded. Your withdrawal from the study will in no way affect your access to or the use of traditional plant medicines or pharmaceuticals.

If you agree to participate in this study, you will be asked to sign a consent and access and benefit sharing agreement which will protect and inform you of your rights as a participant. Thank you for taking the time to read this leaflet. If you are unclear about anything or need further information, feel free to contact us at:

Procedures:

If you participate in this study, you will ask questions which will be recorded. Your participation is completely voluntary. You may withdraw from this study at any time without penalty.

Benefits and Risks:

No risk greater than those experienced in ordinary conversation are anticipated. Everyone will be asked to respect the privacy of the other group members. All participants will be asked not to disclose anything said within the context of the discussion.

Confidentiality:

Anonymous data from this study will be analysed by the researchers. No individual participant will be identified or linked to the results. Study records, including this consent from signed by

you will be kept in a locked office at the University of Namibia the Western Cape. The results of this study will be used for thesis and may be presented at meetings and seminars; however, your identity will not be disclosed. All information obtained in this study will be kept strictly confidential.

Consent:

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this focus group.

Participant's signature: _____



APPENDIX 5: Informed consent for video recording

UNIVERSITY OF THE WESTERN CAPE: DEPARTMENT ANTHROPOLOGY AND SOCIOLOGY. Private Bag X17, Bellville, 7535, Cape Town, South Africa Tel: (021) 959-2336; Fax: (021) 959-2830

Title: The use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.

You are invited to participate in a study on **the use of medicinal plants to treat mental illness in Kavango east and west regions, Namibia.** With your permission, our conversations will be video recorded and data will be used for documentation, research, and publication. If you wish, pseudonyms will be used. If you would like to see the information about yourself and/or what you said at any time, you can do so. I will keep your identity strictly confidential. You may withdraw from this study whenever you wish, and if you do, all information you provided will be discarded. Your withdrawal from the study will in no way affect your access to or the use of traditional plant medicines or pharmaceuticals.

If you agree to participate in this study, you will be asked to sign a consent and access and benefit sharing agreement which will protect and inform you of your rights as a participant. Thank you for taking the time to read this leaflet. If you are unclear about anything or need further information, feel free to contact us at:

Procedures:

If you participate in this study, you will ask questions which will be recorded. Your participation is completely voluntary. You may withdraw from this study at any time without penalty.

Benefits and Risks:

No risk greater than those experienced in ordinary conversation are anticipated. Everyone will be asked to respect the privacy of the other group members. All participants will be asked not to disclose anything said within the context of the discussion.

Confidentiality:

Anonymous data from this study will be analysed by the researchers. No individual participant will be identified or linked to the results. Study records, including this consent from signed by you will be kept in a locked office at the University of Namibia the Western Cape. The results of

this study will be used for thesis and may be presented at meetings and seminars; however, your identity will not be disclosed. All information obtained in this study will be kept strictly confidential.

Consent:

By signing this consent form, you are indicating that you fully understand the above information and agree to participate in this focus group.

Participant's signature: _____



APPENDIX 6: Michael Shirungu & Nguwo a traditional healer whom the local have nicknamed as Kasenge. Below is the certificate fom NETHA.



MEMBERSHIP CERTIFICATE

WESTERN CAPE TRADITIONAL HEALERS ASSOCIATION
 P.O. Box 24103
 Windhoek
 Namibia
 Tel: (061) 218480
 Reg. NO. W083

NETHA "Head Office"
 New Tel: (061) 246168-9
 After hours: (061) 237219

Ref. Name: NGUWO
 Surname: MASHANGO
 I.D. Number: 2004080700011
 Place of Birth: RUNISU
 Date of Birth: 05-04-20
 Nationality: NAMIBIAN

This is to testify that the bearer of this certificate is a traditional healer and is authorised by the Namibia Eagle Traditional Healers Association (NETHA) to practice traditional medicine.

Signature, Secretary General [Signature]
 Signature, Chairman [Signature]
 Date Issued: 18-09-96