Psychology in society, 1990, 14, 47-62

Indigenous healers in a future mental health system: A case for cooperation

Ilana Korber
Department of Psychology
University of Cape Town
Cape Town

INTRODUCTION

There has been a great deal of debate about the relative merits of western psychiatry and what is generally known as traditional medicine or healing. Numerous anthropologists, psychologists, psychiatrists and other interested parties have investigated the area. Some have suggested that western psychiatry has a lot to learn from traditional methods; others have argued that traditional medicine is primitive, even dangerous, and should have no place alongside the western system of healing. This paper argues that regardless of the position adopted in the debate, the de facto situation reveals that both systems are widely used in South Africa. Thus, in discussing a future mental health system, it would be inappropriate to disregard a system of healing which is not only popular but will also contribute to the provision of mental health facilities to as many South Africans as possible. It will be suggested that a high level of cooperation, rather than a hybrid psychiatric system, be developed.

The need for cooperation is raised throughout the paper and is based on an appraisal of the relevant literature and an assessment of some of the issues which need to be discussed. The paper first takes a brief look at previous research on indigenous medicine. It then focuses on the use of indigenous healers in South Africa and observes that both indigenous and western systems are relied upon. The coexistence of the two systems in

Southern Africa is then briefly addressed. Arising from the coexistence of these two systems the question of the professionalisation of indigenous healers in South Africa is discussed. Finally, the paper argues that cooperation between the two systems is required and some of the obstacles are raised.

Freeman (1989a) estimates that there are some five million South Africans requiring treatment for mental disorders with about 330 000 of these people incapacitated by their condition. In order to address these needs, a primary mental health system is proposed. Such a system is based on four principles: "mental health care should be made available near to where people live; mental health care should be administered by appropriately skilled personnel (and not by either over- or underqualified staff); prevention of ill-health and promotion of mental health should form an integral and important part of mental health care; mental health care should be community based and controlled" (Freeman, 1989b, pp3-4).

He suggests that the four major obstacles to these goals are the present centralisation and concentration of services, overloaded general health care personnel, limitations of the legislation and the stigmatisation of mental illness. Freeman (1989a) makes numerous valuable suggestions which will facilitate the overcoming of these obstacles. He does not, however, mention the necessity of cooperating with indigenous healers who are well placed to assist in the provision of mental health care.

INDIGENOUS MEDICINE: A BRIEF EXAMINATION

Indigenous medicine covers a wide range of practices including the nyanga and the sangoma among the Zulu, the molopo among the Pedi, the dingaka among the Sotho, and the igqira among the Xhosa (Schweitzer, 1980). Each has his/her own field of expertise and set of practices. These may differ from one section of Nguni society to another (Ngubane, 1977).

Much of the literature categorises these practices as traditional medicine. Spiegel and Boonzaier (1988) argue that "the term 'traditional' is used in South Africa to label an entire category of people whose behaviour and thinking are portrayed negatively. They are seen as 'conservative', 'backward', 'pre-rational' and therefore fundamentally unable to compete with 'modern', 'progressive' or 'developed' people. This usage is entirely compatible with discriminatory ideas which refer to racial differences and inferiority" (p43). It is for this reason that this article refers to indigenous

medicine which,as Schweitzer comments, "has a dynamic connotation in that it is always related to an environment and is present-oriented" (1980b, p246).

Spiegel and Boonzaier (1988) criticise much of the research on indigenous medicine for failing to address the political and economic aspects involved in the choice of health system. African people do not choose to use indigenous healers simply because of their adherence to an African cosmology. While this might be a motivating factor in some instances, access to western medicine is often difficult and unsatisfactory. On the whole, both systems are used. Spiegel and Boonzaier (1988) conclude that if their choice were "simply determined by their 'traditional' outlook, African patients would never seek assistance from Western medicine" (p45).

Boonzaier (1985) points out that throughout the western world people make use of alternative healing systems in addition to the western medical system. If white South Africans are treated by homeopaths, acupuncturists and a range of "alternative" practitioners in addition to doctors, why is it considered so strange that blacks also make use of a variety of healing systems? If the explanation lay exclusively in the power differential between western and alternative medicine, one would expect that the patterns of choice amongst whites would also have attracted some academic interest.

Part of the concern in investigating black people's use of indigenous medicine would seem to be rooted in the discourse of culture and cultural differences so salient to South African research. It is important to note that most of the research in this field has been conducted by white academics investigating the black "world view". As Schoeman (1985) observes, "no matter how much one wishes to enter the other person's world, one remains situated in your own cultural context. One's perception of events, your interpretations and descriptions, are all codetermined by the consensually validated concepts and categories of thought of your own culture" (p7). It is difficult within the Apartheid and colonial context to overcome the primitive-western, black-white, desirable-undesirable, them-us dichotomies.

It is within this context that the debate about cultural relativism becomes overlaid with political and ideological complexities. While this debate is well summarised by Fabrega (1989), a few points still need to be made

about the context within which the issues are raised in South Africa. If one accepts the relativist position that different cultures exist which give rise to unique illnesses, one is in danger of lending support to the Apartheid ideology notion of "separate but equal". On the other hand, the universalist position is unsatisfactory because it seeks to impose the western medical model on all societies and cultures, thus ignoring the important differences. Kottler (1990) introduces an important element to this discussion in focussing on the political and psychological implications of the "similarities" and "differences" discourses.

It would seem that adopting an either-or position in this debate is inadvisable and that one should rather draw what is useful from both positions. Although Fabrega argues that these positions are contradictory, it is not problematic to argue that while there exist certain universals, there exist simultaneously certain differences. Within the South African context these should be seen as enriching rather than as a motivation for separating and dividing facilities and people.

USE OF INDIGENOUS HEALERS

It is clear from the many studies conducted that South Africans make use of a variety of systems and facilities (Oberholzer, 1985; Allwood, 1986; De Beer, 1979, Holdstock, 1979). It is also evident that those who make use of indigenous medicine do so in addition to western medicine. A range of explanations for this phenomemon have been suggested. Gillis (1989) provides an evolutionist and somewhat paternalistic account of how black peoples' attitude towards western medicine is dependent on their degree of urbanisation. Ngubane (1981) and Boonzaier (1985) focus on issues of accessibility, while others examine the preferred method of diagnosis and explanation of illness (Daynes & Msengi, 1979; Chavanduka, in Gelfand, Mavi & Drummond, 1978) provided by indigenous healers.

The studies already cited indicate that, in the urban areas, there is a measure of "shopping around" for the best cure. Considering the lack of access to western medicine in the rural areas, it is likely that a large section of the population relies on indigenous healers. It seems likely that this trend will continue particularly in the context of a health system skewed in favour of a small section of the population.

In South Africa most psychiatrists and psychologists are white (Swartz, 1987), as are most of their patients (Bassa & Schlebusch, 1985, p20). Black

patients are cared for mostly by psychiatric nurses (Allwood, 1986, p6). Facilities are clustered in the urban areas with rural areas very poorly serviced. Even in the urban areas psychiatric services are far more accessible to white than to black South Africans. The psychiatrist-patient ratio for whites is estimated at 1:25 000 whereas the ratio for blacks is 1:500 000 (Allwood, 1986, p5). It is estimated that in 1978 there were roughly 1 600 indigenous healers in Soweto and 15 resident doctors (Panel discussion in **The Leech**, p20). Webber comments that "there are 15 doctors in Soweto ...not because the people don't want doctors, but because doctors don't make their services available and the people don't have free choice between the two systems of medicine" (**The Leech**, p20).

In addition to inaccessiblity, the problems of cultural and racial chauvinism, methods of assessment and treatment offered, and doctors' ignorance of African languages might make western medicine the second choice of many black South Africans. As Spiegel and Boonzaier (1988) note, the number of indigenous healers is increasing rather than decreasing. Unless the planners of a primary mental health care system acknowledge the important role of the indigenous healers, the goal of health for all will be elusive.

Although very little material on mental health has been published by the ANC, it is interesting to note that it has endorsed the primary health care model and has also recognised the important role of the indigenous healers. Dommisse (1988) quotes from an ANC Health Department policy statement made in 1986 in which the "isangoma" is discussed. "Traditional healers and midwives have always played an important role in providing health care, both physical and mental, to our people...It is true that while some of the practices are unscientific and may even be harmful, many are effective and are seen to be so by the people" (p327). [Further discussion about the details of a national health service are included in a booklet containing the proceedings of a joint ANC-NAMDA meeting in October 1989 (NAMDA,1990).] Clearly there is a vast difference between acknowledging the importance of indigenous healers and ensuring that they are incorporated in some way into future health structures. It is therefore critical that discussion proceed with a focus on the practical implications.

Freeman (1989c) argues that a future mental health system should focus on preventative strategies and non-psychotic disorders. The present focus has been on psychotic disorders and has stressed a curative approach. This

has led to "the neglect of preventive and promotive strategies in mental health care and to a lack of attention to non-psychotic disorders which are predictably present in any society but are likely to be more so in a country like South Africa where political oppression and economic deprivation predispose to a range of non-psychotic problems" (p12).

Whether psychiatrists or traditional healers are best able to treat these psychotic and non-psychotic disorders will continue to be debated. Freeman raises this problem in the Zimbabwean context where it is "widely speculated...that neurotic problems can be treated by a nyanga while psychotic problems should be left for advanced western medicine" (1988, p35).

Much has been written about the therapeutic benefits of the indigenous healers (Holdstock, 1979; Bührmann, 1980 & 1983). Schweitzer (1980b) concludes that it is difficult to assess the efficacy of indigenous therapy. This is because "the goals and objects of treatment are not defined within a biomedical idiom and they can therefore not be meaningfully assessed in terms of the usual procedures employed in clinical practice" (p249). This raises the question of how an assessment is made about which systems should be promoted for the treatment of various conditions.

What is more important than the clinical similarities and differences is the way in which the conditions are perceived in the communities in which they present and the consequent treatment. Experiences such as hallucinations, for example, are viewed differently depending upon the cultural context (Hammond-Tooke, 1975) and are treated according to the interpretation given by each system. The indigenous and biomedical approaches appear to differ to the extent that it seems impossible to combine them. It therefore seems preferable that each system continue to practice within its own framework and that patients have access to both. As South Africa moves towards a new political dispensation and policies for a new mental health system are devised, this debate will probably become increasingly intense.

COEXISTENCE OF INDIGENOUS AND WESTERN SYSTEMS

It might be instructive at this point to examine the experience of other Southern African countries that have dealt with the coexistence of western and indigenous healing systems. Fassin and Fassin (1988) discuss four categories of official attitude to indigenous healers in certain African

countries. The first covers the situation where it is illegal but the law is unenforced, secondly it is unofficially recognised, thirdly it is legalised, and fourthly it is integrated into primary health care.

Chavanduka (1986) describes the situation in Zimbabwe where indigenous healers were legalised in 1981 and are organised into the Zimbabwe National Traditional Healers' Association (ZINATHA). He says that for some three years after the establishment of this association, the popularity of the healers grew as a result of increased awareness of their successes. In addition, the colonial stigma attached to indigenous healing began to disappear. The association has two medical schools and four clinics. The healers are instructed to seek a second opinion if a patient does not show signs of improvement and to refer patients to hospitals and clinics for certain diseases which western medicine is ostensibly better able to treat. Chavanduka comments that while the healers are prepared to cooperate with doctors, "many of them are opposed to the idea of working alongside them in hospitals and clinics. They prefer to continue working in their own homes as at present. A few now have clinics or hospitals of their own. They have no objection to exchanging patients and information" (1986, p41).

In a discussion of indigenous healers in Ghana and Zambia, Twumasi and Warren (1986) conclude that they are the "first line of contact in most areas" (p134). They argue that these healers have been influenced by western health practices and that doctors are increasingly viewing them as collaborators in the effort to provide a national health service. With government aid, these healers are developing into "an occupational group acceptable to modern Ghanian and Zambian societies" (p134). Similar processes seem to operate in other African countries (Staugard, 1986; MacCormack, 1986; Reynolds, 1986; Semali, 1986).

Ben-Tovim (1987, cited in Flisher, 1990) found that indigenous healers have not been incorporated into the Primary Health Care system in Botswana. This is due to the apparent incompatibility of the two systems as well as the problems involved in attempting to integrate the "individualistic" healers into the bureaucracy. However, it appears that the systems complement each other "with the traditional tending to be the preferred mode of treatment" (p47).

PROFESSIONALISATION OF INDIGENOUS HEALERS

The coexistence of the western and indigenous healing systems raises the question of the professional status of the latter. Kottler (1988) raises the interesting point of who wants to professionalise these healers and why. She suggests that western medicine is threatened by indigenous healers. Medical practitioners recognise that the indigenous system "cannot be ignored (because patients use it, because of the population explosion and because of the lack of resources)" (p13). There is thus a "concerted effort on the part of Western medicine to change African medicine" (p13). She suggests that professionalisation and consequent undergoing of western training is one of the ways in which this change could be effected.

Chavanduka (cited in Kottler, 1988) makes a tactical suggestion that professionalisation would prevent political impotence in the face of the powerful medical system. However, as Fassin and Fassin (1988) observe, official recognition is not required by healers whose reputation ensures that they are continually consulted by patients ranging "from the peasant to the President of the Republic" (p354). They argue that it is "self-proclaimed healers" who have the most to gain from the process of officialisation and conclude that "the stronger the traditional legitimacy, the less need for rational-legal legitimation" (p355).

Do South Africa's indigenous healers have any interest in professionalising? This is likely to be a source of contention amongst the healers themselves, some of whom stand to benefit more than others. In addition to the question of legitimacy, it is possible that competition with other systems will complicate the healers' opinion about professionalising. In rural areas, where western medical services are very thinly spread, healers could benefit from state resources while not necessarily facing increased competition from medical practitioners. However, the urban healers, while benefitting in terms of resources, might find themselves constrained by controls to an extent not imposed upon their more distant, rural counterparts.

The economic threat which indigenous healers pose to doctors should not be underestimated as a factor in the debate about professionalisation, both in terms of access to patients' fees as well as to state resources. If indigenous healers were to be professionalised, they would presumably receive state assistance. The health pie would thus have to be further divided. This could lead to an increasingly antagonistic relationship between indigenous healers and doctors. It illustrates the way in which

attempting to control indigenous healers through professionalisation could serve to threaten the western system further, through strengthening the economic power of the healers.

Whether or not South Africa's indigenous healers are to be professionalised remains to be seen. In the meantime the implications of professionalisation must be made explicit. Will indigenous healers be expected to register with a professional body and if so which one? Will they have to complete certain prescribed medical courses? Will they be bound by official tariffs and will they be contracted to medical aid schemes? Will they be expected to practice within the confines of existing hospitals and clinics and will their services be restricted to particular areas of pathology? What will be the nature of the cooperation between indigenous healers and western practitioners? These and numerous other questions have to be addressed in designing a future mental health system.

Notwithstanding the healers' attitudes towards professionalisation, it is not at all clear whether there is pressure in this direction from currently existing medical bodies. Judging from the experiences of other countries discussed earlier, however, it can be assumed that this issue will become prominent in the not too distant future. When this occurs it will be important to avoid a situation wherein the issues of power override the health requirements of the population.

In order for the debate to progress in a meaningful way, the opinions of indigenous healers will have to be sought. The appropriate forums for such discussion need to be found. Articles in academic journals serve the limited purpose of stimulating discussion in certain circles, but energies should be geared towards the real debate amongst all concerned parties.

Any discussion about professionalisation must also be considered in the context of the need to decentralise and, where appropriate, to deprofessionalise mental health services. Whether professionalising indigenous healers would promote these objectives is debatable. Discussion should not be limited to the questions of the professionalisation of indigenous healers, but should extend to cover the nature of the mental health problems that should receive attention as well as preventative programmes that could be introduced. Responsibility for these areas could then be productively discussed in the spirit of improving the mental health of the population.

Ultimately, what is really at issue in this discussion seems to be the power struggle between systems as regards access to patients and resources as well as professional controls. This can only serve to obscure the needs of the patients. The accompanying debate over which system provides better clinical services depends largely on the orientation of the participants and it is unlikely that empirical evidence will settle the matter. However, if the patients' orientation is to be assessed from their help-seeking actions, then it must be accepted that both systems are widely used, regardless of their relative merits and failings. If the needs of the patient are to be met in the future, a level of integration or cooperation must therefore be attempted.

TOWARDS COOPERATION

It is this cooperation that such researchers as Schweitzer (1980b) and Levenstein (1989) have recognised as necessary for a future mental health system in South Africa. The precise mechanisms and parameters of such cooperation will necessitate consultation not only between the western and indigenous healers but also between the relevant government departments, doctors and the consumer. This process of consultation raises a host of problems which will have to be addressed. Assuming that such a process is embarked upon, who will comprise the health department and who will be consulted? The indigenous healers do not belong to any one structure which could be mandated to negotiate on their behalf. The logistical problems involved in canvassing opinion from this sector could prove to be overwhelming. The currently existing medical bodies are politically divided and even within these groupings differences exist which could hamper the process of consultation.

The requirements of the consumer also have to be assessed. Assuming the government's commitment to such a process, how will these needs be ascertained? It is possible that a government-sponsored survey could be run in order to gather the necessary information. However, in addition to the methodological and logistical problems involved, the financial and bureaucratic constraints facing the health department make it an unlikely venture.

The precise nature of such cooperation is difficult to predict at this point because of the lack of discussion amongst all relevant parties. In the meantime, several questions can be posed. Swartz (1986) raises a number of problems including "who holds the ultimate power", who holds "ultimate clinical responsibility" and whether either the indigenous or biomedical

system has "the right to veto procedures which it feels may be pathogenic" (p289). Any discussion attempting to address these issues will require a broadminded approach rather than a parochial one based on the interests of particular groupings. It will necessitate an acceptance of the sharing of resources amongst all those engaged in the mental health field as well as a commitment from the government to distribute these in such a manner.

This debate is not a new one and a number of divergent opinions have been expressed about how the different approaches could be integrated. Lifschitz (1989) argues for a hybrid system which will "draw from both Western and African approaches to healing" (p50). Schweitzer (1980b) also tends towards an integrated approach. Hammond-Tooke (1989, p154) offers "a cautious yes" as to whether collaboration is possible between the western doctor and the indigenous healer. Cooperation is suggested by many practitioners (Allwood, 1986; Gillis, 1987; Holdstock, 1979; Edwards, 1986; Robbertze, 1980).

CONCLUSION

This paper is not an argument in favour of amalgamation. A hybrid approach may well lose what is most useful about each system in an attempt to integrate methods of diagnosis and treatment. Rather, the merits of each system should be recognised and developed and a spirit of cooperation fostered. On a practical level, there should be cross-referals as well as joint discussion about healing approaches and training. As this is already taking place informally, in the sense that patients often make use of both systems simultaneously, practitioners can only benefit from the formalisation of such an approach.

An open approach to cooperation might encourage mutual respect and sharing of knowledge. This will develop not only at the level of practitioners and students, whose training will have to be adapted appropriately, but also amongst patients who should be informed about the benefits of various treatment options. Cooperation will ultimately extend the mental health services to a greater proportion of the population, will benefit those who use them, and will bring South Africa closer to the WHO goal of Health for All by the Year 2000.

Acknowledgements: Sincere thanks to Leslie Swartz for assistance and comments.

RERERENCES

Allwood, C W (1986) Alternative mental health workers for Southern Africa. **Psychotherapeia, 44,** 5-9.

Bassa, F M & Schlebusch, L (1985) Characteristics of clinical psychologists and the patients who consult them. **Psychotherapeia, 37,** 20-36.

Boonzaier, E (1985) Choice of healer: An important area of interest for general practitioners. **SA Family Practice, 6,** 236-240.

Bührmann, M V (1977) Western psychiatry and the Xhosa patient. **SA Medical Journal, 51,** 464-466.

Bührmann, M V (1980) Why are certain procedures of the indigenous healer effective?, in Wilson, F & Westcott, G (eds.) **Economics of health in South Africa**. (Vol II). Johannesburg: Ravan.

Bührmann, M V (1983) Community health and traditional healers. **Psychotherapeia, 30,** 15-18.

Bührmann, M V (1982) Thwasa and bewitchment. **SA Medical Journal, 61,** 877-879.

Chavunduka, G L (1986) Zinatha: The organisation of traditional medicine in Zimbabwe, in Last, M & Chavunduka, G L (eds.) **The professionalisation of African medicine**. Manchester: International African Institute.

Daynes, G & Msengi, N P (1979) "Why am I ill? Who made me ill?" - the relevance of Western psychiatry in Transkei. **SA Medical Journal, 56,** 307-308.

De Beer, F R (1979) Meerdeelige opname onder swartes in stedelike gebiede, 1978. Besoeke aan toerdokters. Institute for Sociological and Demographic Research, HSRC, Pretoria, Publication S-N-171.

Dommisse, J (1988) Health and health care in post-Apartheid South Africa: A future vision. **Journal of the National Medical Association, 80,** 325-333.

Edwards, S D (1986) Traditional and modern medicine in South Africa: A research study. **Social Science and Medicine, 22,** 1273- 1276.

Fabrega, H (1989) Cultural relativism and psychiatric illness. **Journal of nervous and mental disease, 177,** 415-430.

Fassin, D, & Fassin, E (1988) Traditional medicine and the stakes of legitimation in Senegal. **Social Science and Medicine, 27,** 353-357.

Flisher, A (1990) Book review of "Development psychiatry: Mental health and primary health care in Botswana" by David Ben-Tovim. **Psychology in society, 13,** 45-48.

Freeman, M (1988) Mental health in Zimbabwe: Are there lessons for South Africa? **Psychology in society, 9,** 22-43.

Freeman, M (1989a) Paving the road towards a primary mental health care approach in South Africa. Paper No.18, Centre for the Study of Health Policy, University of Witwatersrand, Johannesburg.

Freeman, M (1989b) Suggestions for short term improvements in community rural mental health care - the example of the Mhala district in the Eastern Transvaal. Paper No.19, Centre for the Study of Health Policy, University of Witwatersrand, Johannesburg.

Freeman, M (1989c) Mental health crisis in South Africa. Paper No.16, Centre for the Study of Health Policy, University of Witwatersrand, Johannesburg.

Gelfand, M, Mavi, S, & Drummond, R B (1978) The role of the witchdoctor in African health care. **The Leech, 48**(2), 16-19.

Gillis, L S (1977) Psychiatric illness in Africa, in Gillis, L S **Guidelines in psychiatry** (2nd ed.). Cape Town: Cape & Tvl Printers.

Gillis, L S (1989) Improving compliance in Xhosa psychiatric patients. **SA Medical Journal, 76**, 205-208.

Hammond-Tooke, W D (1975) African world-view and its relevance for psychiatry. **Psychologia Africana, 16**(1), 25-32.

Hammond-Tooke, W D (1989) **Rituals and medicines: Traditional healing in South Africa**. Johannesburg: AD Donker.

Holdstock, T L (1979) Indigenous healing in South Africa: A neglected potential. **South African Journal of Psychology, 9**, 118-124.

Kottler, A (1988) Professionalisation of African healers: Apparent problems and constraints. **Psychology in society, 11**, 2-17.

Kottler, A (1990) South Africa: Psychology's dilemma of multiple discourses. **Psychology in society, 13**, 27-36.

Kruger, D (1978) Towards an understanding of the Xhosa diviner. **The Leech, 48**(2), 7-13.

Levenstein, S (1989) Mental health in South Africa, in Owen, C P (ed.) **The case for a national health service**. Cape Town: Department of Adult Education and Extra-Mural Studies (UCT) & NAMDA.

Lifschitz, S (1989) The story of the cave or finding ways to create psychotherapeutic contexts with black clients, in Mason, J B & Rubenstein, J (eds.) **Family therapy in South Africa today**. Congella: South African Institute of Marital and Family Therapy.

MacCormack, C (1986) The articulation of western and traditional systems of health care, in Last, M & Chavunduka, G L (eds.) **The professionalisation of African medicine**. Manchester: International African Institute.

NAMDA (1990) Towards a national health service, in **NAMDA Special Bulletin 3**. (NAMDA-ANC meeting October 1989) Durban: NAMDA Publications.

Ngubane, H (1977) **Body and mind in Zulu medicine: An ethnography of health and disease in Nyuswa-Zulu thought and practice**. London: Academic Press.

Ngubane, H (1981) Aspects of clinical practice and traditional organization of indigenous healers in South Africa. **Social Science and Medicine**, 15B, 361- 365.

Oberholzer, D J (1985) Cooperative venture with traditional healers in providing a community mental health service in the Odi I district, Bophuthatswana: A preliminary review. **Psychotherapeia and Psychiatry in Practice, 36**, 36-42.

---- (1978) Panel Discussion **The Leech, 48**(2), 19-24.

Reynolds, P (1986) The training of traditional healers in Mashonaland, in Last, M & Chavunduka, G L (eds.) **The professionalisation of African medicine**. Manchester: International African Institute.

Robbertze, J H (1980) Mental health priorities in South Africa, in Wilson, F & Westcott, G (eds.) **Economics of health in South Africa Vol II**. Johannesburg: Ravan.

Schoeman, J B (1985) Vera Bührmann's approach to cultural psychiatry. **Psychotherapeia and Psychiatry in Practice, 36**, 7-12.

Schweitzer, R (1980a) Indigenous therapy in Southern Africa **Bulletin of the British Psychological Society, 33**, 278-281.

Schweitzer, R (1980b) Mental health services in an African context: Alternative modes of service, in Wilson, F & Westcott, G (eds.) **Economics of health in South Africa Vol II**. Johannesburg: Ravan.

Schweitzer, R (1985) Folk healing among the Xhosa speaking people. **Psychotherapeia and Psychiatry in Practice, 36**, 27-35.

Seedat, A (1984) **Crippling a nation: Health in Apartheid South Africa**. London: IDAF.

Semali, I A J (1986) Associations and healers: Attitudes towards collaboration in Tanzania, in Last, M & Chavunduka, G L (eds.) **The professionalisation of African medicine**. Manchester: International African Institute.

Spiegel, A & Boonzaier, E (1988) Promoting tradition: Images of the South African past, in Boonzaier, E & Sharp, J (eds.) **South African Keywords: The use and abuse of political concepts**. Cape Town: David Philip.

Staugard, F (1986) Traditional health care in Botswana, in Last, M & Chavanduka, G L (eds.) **The Professionalisation of African medicine**. Manchester: International African Institute.

Swartz, L (1986) Transcultural psychiatry in South Africa. Part I. **Transcultural Psychiatric Research Review, 23**, 273- 303.

Swartz, L (1987) Transcultural psychiatry in South Africa. Part II. **Transcultural Psychiatric Research Review, 24**, 5-30.

Twumasi, P A & Warren, D M (1986) The professionalisation of indigenous medicine: A comparative study of Ghana and Zambia, in Last, M & Chavunduka, G L (eds.) **The professionalisation of African medicine**. Manchester: International African Institute.